

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 4001	
BIRTH NO. 67 4001		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) PEARL BATZER		2. DATE AND HOUR OF DEATH April 22, 1967. 7:15 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 Gould Convalesarium		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Anne Arundel Co. C. CITY OR TOWN (If outside city limits, write RURAL and give township) Riviera Beach 32-00 D. STREET ADDRESS (If rural, give location) 223 Harlem Road			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH Feb. 1, 1886.	9. AGE (In years last birthday) 81	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Robert Harris		14. MOTHER'S MAIDEN NAME Unknown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-22-3978		17. INFORMANT Mr. Gerard Batzer ADDRESS Bradshaw, Md.	
18. 443X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) DUE TO Cerebral Hemorrhage (B) DUE TO Hypertensive Cardio-Vascular Dis. (C) Degenerative Arthritis		INTERVAL BETWEEN ONSET AND DEATH 2 hrs. 4 yrs. 15 yrs.	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Aug. 29 1966 to April 22 1967, that (I) (we) last saw the deceased alive on Apr. 22 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Clifford F. Hudson M.D.				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) CLIFFORD F. HUDSON M.D.		23D. ADDRESS FORK, MD.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/26/67.		24C. NAME OF CEMETERY or CREMATORY Meadowridge Memorial Cem.	
24D. LOCATION (City, town, or county) (State) Elkridge, Md.					
25A. DATE RECEIVED BY HEALTH DEPT. APR 24 1967		25B. NAME OF REGISTRAR Robert E. Fulkerson		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21211	

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BALTIMORE CITY HEALTH DEPARTMENT

67 4002

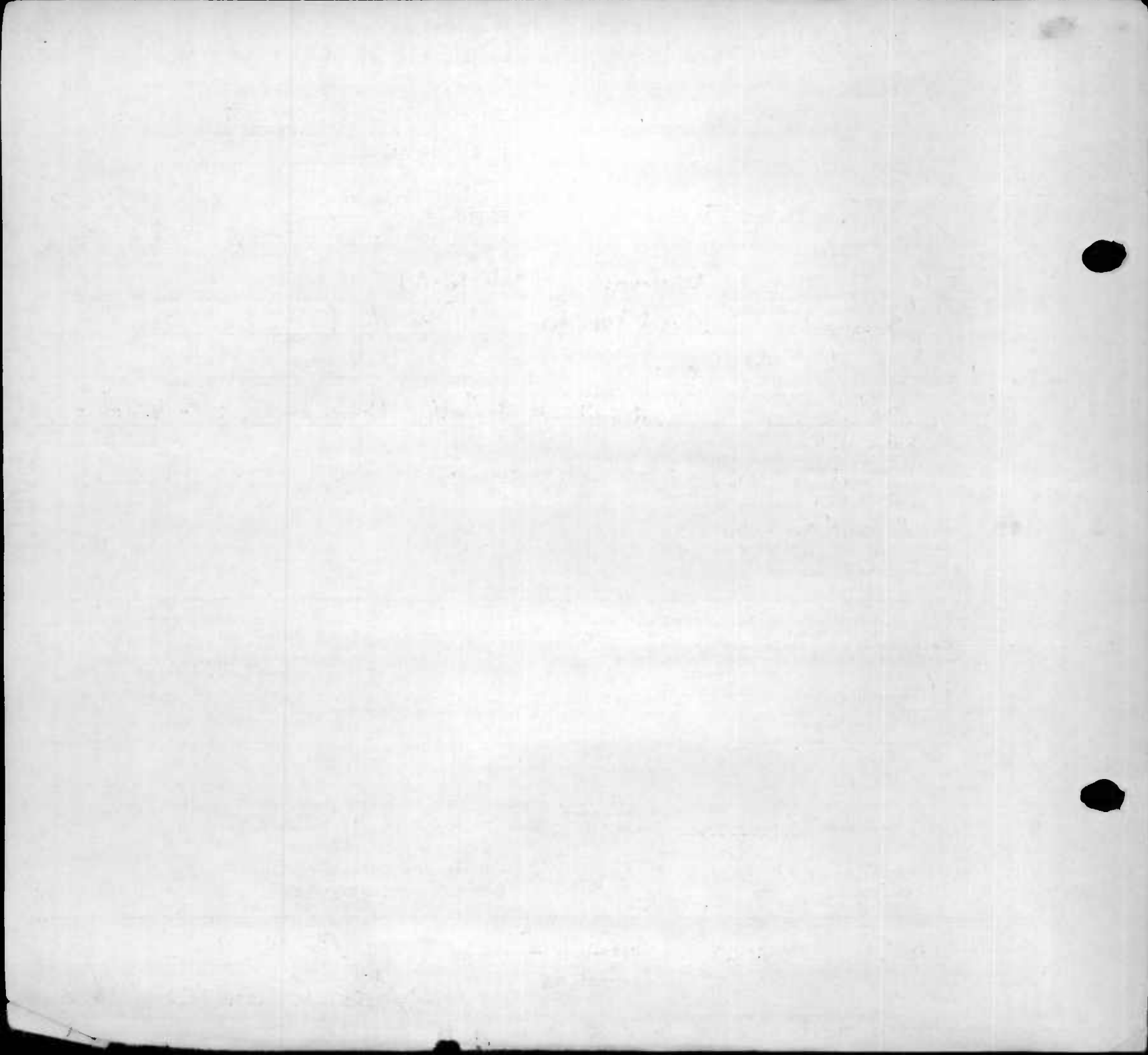
BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) GEORGE F. DAVIS				2. DATE AND HOUR PRONOUNCED DEAD April 19, 1967 6:00 P M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 624 N. Collington Avenue				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 7-03 C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 624 N. Collington Avenue			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 11-12-84	9. AGE (In years last birthday) 82	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10B. KIND OF BUSINESS OR INDUSTRY Kirsch Furniture		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). If yes, give war or dates of service. No		16. SOCIAL SECURITY NO. 21222 2248		17. INFORMANT ADDRESS E. Arthur Bowens 8005 Bellona Ave			
18. CAUSE OF DEATH I 420.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Heart Disease. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Petty M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Charles S. Petty ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 4/20/67							
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 4-21-67		23C. NAME OF CEMETERY, or CREMATORY Baltimore Cemetery		23D. LOCATION (City, town, or county) (State) Baltimore Md.	
24A. DATE RECEIVED BY HEALTH DEPT. APR 24 1967		24B. NAME OF REGISTRAR Robert E. Taylor, M.D.		24C. FUNERAL DIRECTOR ADDRESS 12111 Chesapeake Ave			

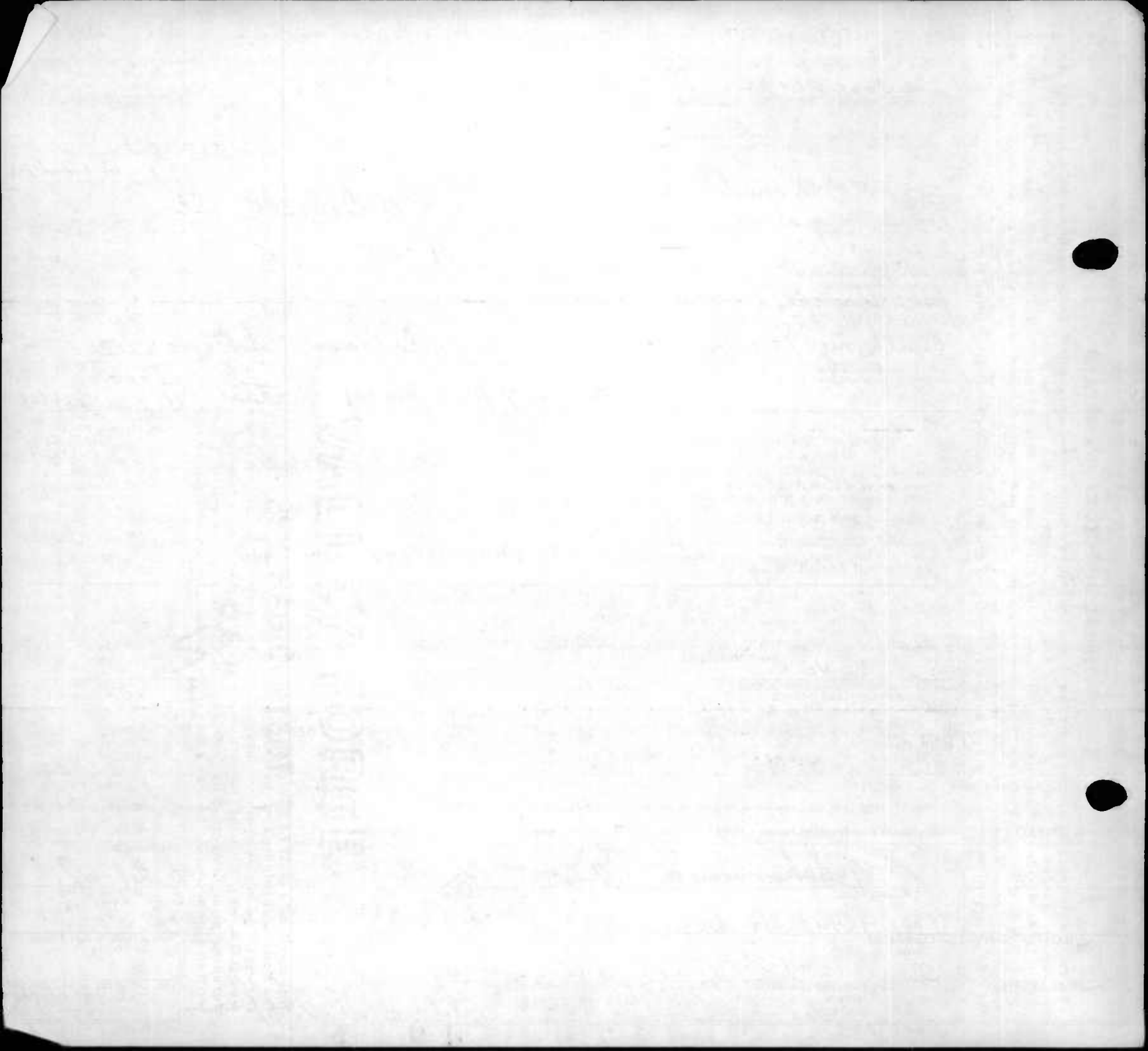
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 67 4003					CERTIFICATE OF DEATH				
M.E. CASE NO.					Registered No. 67 4003				
1. NAME OF DECEASED (Type or Print) Josephine D NOVAK					2. DATE AND HOUR OF DEATH 4-18-67				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY				
FULL NAME OF HOSPITAL OR INSTITUTION 3215 O'Donnell St					C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 2611 21224				
D. STREET ADDRESS (If rural, give location) 3215 O'Donnell St.									
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH 9-29-1888	9. AGE (In years last birthday) 78	10. Under 1 Yr. Months: Days		11. Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife					10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Anthony Dubiel					14. MOTHER'S MAIDEN NAME Magdalena Skwirut				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO. 215-18-2097		17. INFORMANT Mrs. Mary Merten		ADDRESS 4110 Granite Ave
18. 443 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) CEREBRAL HEMORRHAGE DUE TO (B) ARTERIOSCLEROTIC HYPERTENSIVE DUE TO (C) CARDIOVASCULAR DISEASE INTERVAL BETWEEN ONSET AND DEATH FEB 24/67				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. NONE									
19A. DATE OF OPERATION NONE		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED NONE			20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NONE		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) NONE			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) NONE				
21D. TIME OF INJURY (APPROX.) NONE		21E. INJURY OCCURRED While At Work <input checked="" type="checkbox"/> NONE Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR? NONE				
22. I certify that (I) (this hospital) attended the deceased from FEB 24 1967 to APR 18 1967, that (I) (we) last saw the deceased alive on APR 18 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
23A. SIGNATURE E. G. Schimunek M.D.					Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED 4-21-67	
23C. PHYSICIAN'S NAME (Type) EMMANUEL A. SCHIMUNEK M.D.					23D. ADDRESS 842 S. East Ave Cathe Road				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-22-67		24C. NAME OF CEMETERY OR CREMATORY St. Stanislaus			24D. LOCATION (City, town, or county) (State) Md.		
25A. DATE REC'D BY HEALTH DEPT. APR 24 1967		25B. NAME OF REGISTRAR Robert E. Farley			25C. FUNERAL DIRECTOR Thelma H. Hoffmann			ADDRESS 3218 Hudson St.	



BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. **67 4004**

BIRTH NO. **67 4004**

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

STERLING HARDY

2. DATE AND HOUR PRONOUNCED DEAD

4-23-67 10:50 AM

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

UNION MEMORIAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE **MARYLAND**

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2226 N. Calvert Street 21218

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

Mar. 26-16

9. AGE (In years
last birthday)

46 51

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

N.E.

12. CITIZEN OF
WHAT COUNTRY?

U.S.

13. FATHER'S NAME

George Hardy

14. MOTHER'S MAIDEN NAME

Mattie Watson

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS

Sister 333 E. 22nd St.

18. **E902.0**

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) **Craniocerebral injuries**
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)
DUE TO

(C)
DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Fatty liver

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Sidewalk

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

2226 N. Calvert Street

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Minute)

4 23 '67 3:25 AM

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Apparently fell from 2nd story window during delirium tremens

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)

RUSSELL S. FISHER, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☒

ASSISTANT MEDICAL EXAMINER ☐

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4-24-67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

4-27-67

23C. NAME OF CEMETERY or CREMATORY

Wm. Calvary

23D. LOCATION

(City, town, or county)

Balto. Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

APR 24 1967

24B. NAME OF REGISTRAR

Robert E. Fisher

24C. FUNERAL DIRECTOR

**C. W. Wainwright
2700 Edmondson Ave.**

ADDRESS

George Hard

March 16 - 21

Mattie Watson

16-21

21st 23rd 25th 27th

WALLACE BONDAGE

March 16-21 23rd 25th 27th

23rd 25th 27th

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BIRTH NO. 67 4005		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 4005	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR PRONOUNCED DEAD	
		SADIE HARGROVE		April 20, 1967 7:30 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		5. A. STATE	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		Maryland		B. COUNTY	
00 4548 Derby Manor Drive		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)		Baltimore	
		D. STREET ADDRESS (If rural, give location)		4548 Derby Manor Drive	
6. SEX	7. RACE	8. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	9. DATE OF BIRTH	10. AGE (In years last birthday)	11. If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
Female	Negro	Widow	12-18-1897	69	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife				Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
George Brooks		Lucy Brooks			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
				Ernest Hargrove 4548 Derby Manor	
18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
		Arteriosclerotic Cardiovascular Disease.			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO			
		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				No	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK		21F. HOW DID INJURY OCCUR?	
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		Charles S. Petty		DATE SIGNED	
				4/20/67	
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE		23C. NAME OF CEMETERY OR CREMATORY	
Burial		4/23/67		Mt Calvary Em A. A. Co. Md	
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR		24C. FUNERAL DIRECTOR ADDRESS	
APR 24 1967		R. E. Feltman		Rayner Sanders 217 E. Preston St	

WALL & POLYMER

ADDITION

ADDITION

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Written approval must be obtained before the remains are embalmed or final disposition is made.

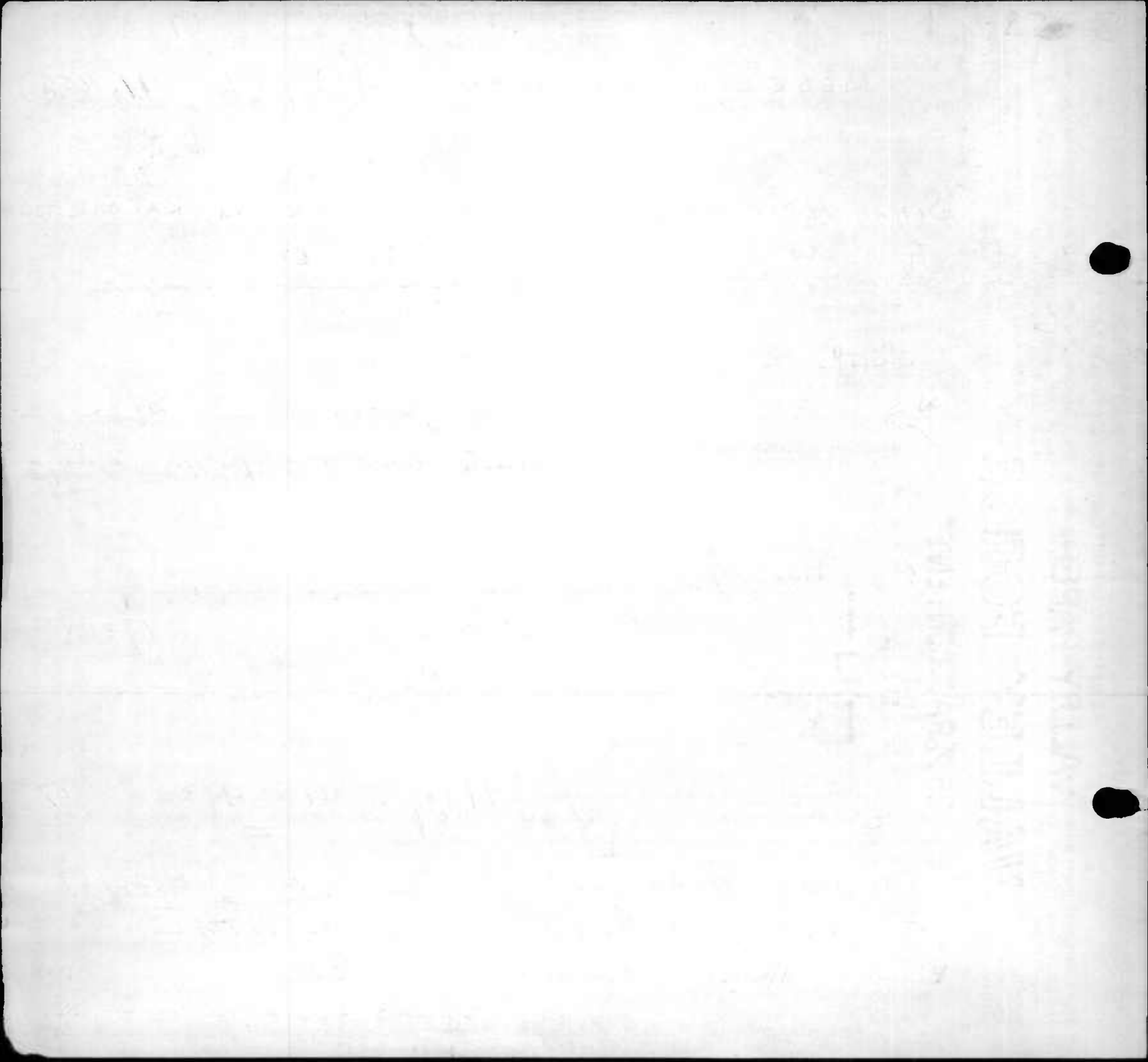
BIRTH NO. 67-08877 4006				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 4006	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) PORTER, BABY GIRL				2. DATE AND HOUR OF DEATH APRIL 21, 1967		12:15 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL				A. STATE MARYLAND B. COUNTY 9.9.6 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 52-00 123 W. Meadow Rd.			
5. RACE FEMALE		6. RACE WHITE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) INFANT		8. DATE OF BIRTH 4-20-67	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NEW BORN		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME RAY R				14. MOTHER'S MAIDEN NAME JEANETTE M. MC CULLEY			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ST. AGNES HOSPITAL RECORDS	
18. 736.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) Prematurity w/ multiple congenital anomalies; - Claw hands & feet (B) T-8 Fistula (C) polycystic kidney		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (X) (this hospital) attended the deceased from APRIL 20 19 67 to APRIL 21 19 67, that (X) (we) last saw the deceased alive on APRIL 21 19 67 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XXXX) view the body after death.							
23A. SIGNATURE Humberto Hernandez				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 4-21-67	
23C. PHYSICIAN'S NAME (Type) HUMBERTO HERNANDEZ, M.D.				23D. ADDRESS BALTO., MD. 21229 ST. AGNES HOSPITAL-CATON & WILKENS AVES.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2 24 67		24C. NAME OF CEMETERY or CREMATORY Cedar Hill		24D. LOCATION (City, town, or county) (State) Brooklyn, A. A. Co. Md.	
25A. DATE RECEIVED BY HEALTH DEPT. APR 24 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Mc Gully		ADDRESS 130 E. Fort Ave	

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital where the physician who pronounced death was in regular attendance on the

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

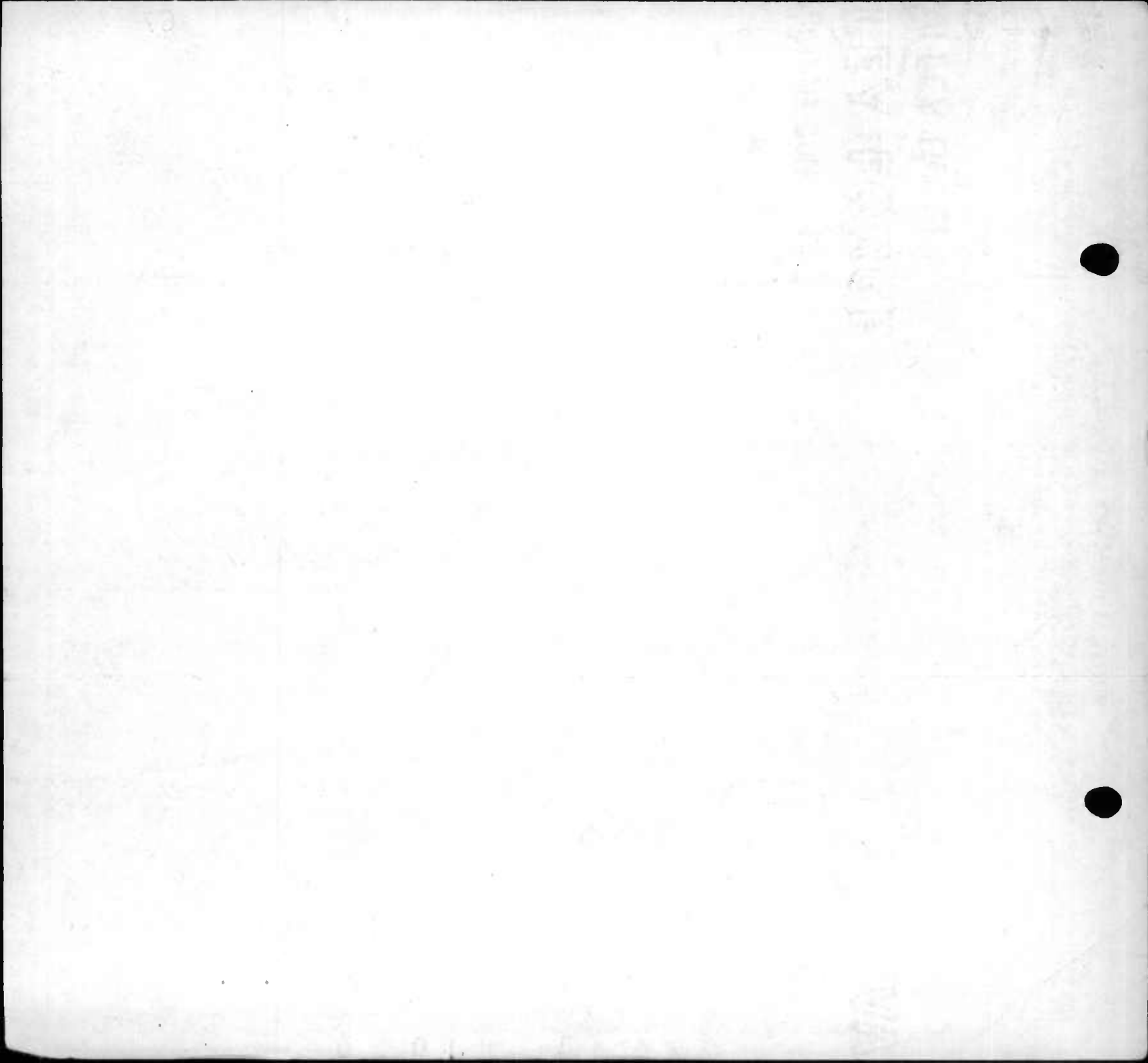
BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 67 4007		CERTIFICATE OF DEATH		Registered No. 67 4007	
1. NAME OF DECEASED (Type or Print) REBECCA SEIDMAN				2. DATE AND HOUR OF DEATH 4/20/67 19:45 (AM)					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY Balti. C C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 53-00 D. STREET ADDRESS (If rural, give location) 8608 LUCERNE Rd, RANDALLSTOWN					
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) M	8. DATE OF BIRTH 10/15/97		9. AGE (In years last birthday) 69	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Abraham				14. MOTHER'S MAIDEN NAME Fannie					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO.		17. INFORMANT Harry Seidman		ADDRESS Same		
18. 4/20/67 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) DUE TO Acute Myocardial Infarction 2 days (B) DUE TO (C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				A.S.H.D years					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 4/18 19 67 to 4/20 19 67 , that (I) (we) last saw the deceased alive on 4/20 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Eduardo Hidalgo M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED 4/20/67		
23C. PHYSICIAN'S NAME (Type) EDUARDO HIDALGO M.D.				23D. ADDRESS Sinai HOSPITAL					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/23/67		24C. NAME of CEMETERY or CREMATORY Rosedale		24D. LOCATION (City, town, or county) (State) Balta Md			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Sylvan S. Lewis & Son, INC			ADDRESS Garrison, Md		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 4008		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 4008	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Norris Lorena Tressel</i>		2. DATE AND HOUR OF DEATH <i>4-21-67</i> <i>12:05</i> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Bolton Co.</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>Franklin Square Hosp.</i>		D. STREET-ADDRESS (If rural, give location) <i>3121 Smith Ave. 27</i>		E. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>33-00</i>	
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widow</i>	8. DATE OF BIRTH <i>1-28-85</i>	9. AGE (In years last birthday) <i>82</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
13. FATHER'S NAME <i>John S. Hawkins</i>		14. MOTHER'S MAIDEN NAME <i>Rosa Clark</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Hospital chart</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Bronchopneumonia</i>		CAUSE OF DEATH (A) DUE TO <i>Fibrosarcoma (Rear) (post op.)</i> (B) DUE TO <i>met & lungs, filat</i> (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <i>acute</i>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>2-2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>4-8</i> 19 <i>67</i> to <i>4-21</i> 19 <i>67</i> . that (I) (we) last saw the deceased alive on <i>4-21</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>K. B. Bum Wee</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>4-21-67</i>	
23C. PHYSICIAN'S NAME (Type) <i>Ki Bum Wee</i>		23D. ADDRESS <i>Franklin Square Hospital</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>4 25 67</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Union Chapel</i>	
24D. LOCATION (City, town, or county) (State) <i>Harford Co. Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>APR 24 1967</i>		25B. NAME OF REGISTRAR <i>Mc Cully</i>	
25C. FUNERAL DIRECTOR <i>Mc Cully</i>		25D. ADDRESS <i>130 E. Fort Ave</i>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 4009				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 67 4009	
1. NAME OF DECEASED (Type or Print) <i>Annie F. Blair</i>				2. DATE AND HOUR OF DEATH <i>April 18/67</i> <i>0910 AM</i>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION <i>Bon Secours Hospital</i> <i>34</i>				A. STATE <i>MD</i>		B. COUNTY			
(If not in hospital or institution, give street address or location)				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>					
				D. STREET ADDRESS (If rural, give location) <i>104 AUGUSTA AVE</i> <i>#29</i>					
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>W</i>	8. DATE OF BIRTH <i>OCT. 1883</i>	9. AGE (In years last birthday) <i>83</i>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEKEEPER</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>HOME</i>			11. BIRTHPLACE (State or foreign country) <i>MD.</i>			12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <i>GEORGE J. FAITER</i>				14. MOTHER'S MAIDEN NAME <i>REITH - MARY</i>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO.		17. INFORMANT <i>Edward Blair - 1045 Augusta Ave</i>			
18. <i>420.11</i>				CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) <i>Recent myocardial infarction</i> DUE TO				<i>days</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <i>Arteriosclerotic heart disease</i> DUE TO				<i>years</i>	
(C)									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <i>2</i>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <i>yes</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <i>April 16 1967</i> to <i>April 18 1967</i> that (1) (we) last saw the deceased alive on <i>April 18 1967</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>A.H. Ghiladi</i> M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>4/18/67</i>			
23C. PHYSICIAN'S NAME (Type) <i>Abdolkhamid Ghiladi</i> M.D.				23D. ADDRESS <i>Bon Secours Hospital</i>					
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>4-21-67</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Catholic Cem.</i>			24D. LOCATION (City, town, or county) (State) <i>Bald. Ind.</i>		
25A. DATE REC'D BY HEALTH DEPT. <i>APR 24 1967</i>			25B. NAME OF REGISTRAR <i>Robert E. Farkner</i>			25C. FUNERAL DIRECTOR <i>Julius Corning BTH International Ind</i>			ADDRESS

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yes

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 4010	
CERTIFICATE OF DEATH					
BIRTH NO. 67 4010					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) LARKIN, MADELINE MARY		2. DATE AND HOUR OF DEATH APRIL 21, 1967		6:45 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION ST. AGNES HOSPITAL		A. STATE MARYLAND 21230			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
		D. STREET ADDRESS (If rural, give location) 1206 BATTERY AVENUE			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 11-27-07	9. AGE (In years last birthday) 59	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME JAMES KRAPP		14. MOTHER'S MAIDEN NAME ANETTA DENGLE KRAPP			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN		16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT ADDRESS CATON & WILKENS AVES., BALTO., MD. 21229	
18. 150X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osseities, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO <i>Laceration of the oropharynx</i> (B) DUE TO <i>Aspiration pneumonia</i> (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from APRIL 19, 1967 to APRIL 21, 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on APRIL 21, 1967 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> (not) view the body after death.					
23A. SIGNATURE <i>Peter Erbguth</i>				23B. DATE SIGNED 4-21-67	
23C. PHYSICIAN'S NAME (Type) PETER ERBGUTH, M.D.				23D. ADDRESS BALTO., MD. 21229 ST. AGNES HOSPITAL-CATON & WILKENS AVES	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4 25 67		24C. NAME OF CEMETERY or CREMATORY Cathedral	
24D. LOCATION Balto. Md.		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. APR 24 1967		25B. NAME OF REGISTRAR <i>Robert E. Salyers</i>		25C. FUNERAL DIRECTOR Mc Gully	
				ADDRESS 130 E. Fort Ave	

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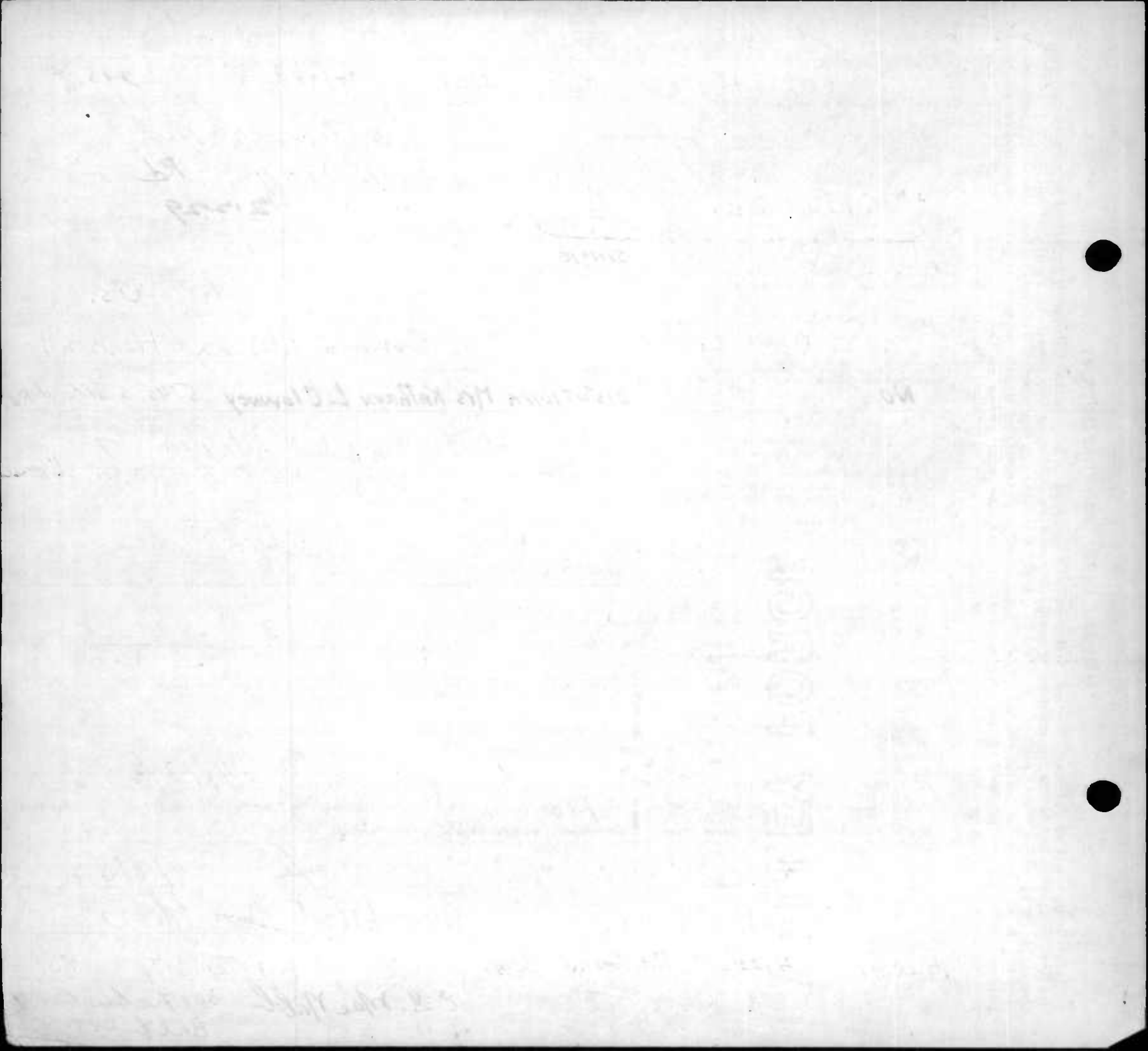
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 4011	
CERTIFICATE OF DEATH					
BIRTH NO. 67 4011					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) <i>Ruth Waters Ruth Waters</i>		2. DATE AND HOUR OF DEATH <i>4/18/67 2:15 P M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>48 Maryland General</i>		A. STATE <i>Baltimore Md</i> B. COUNTY			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>5145 Stafford Rd 25-31</i>			
		D. STREET ADDRESS (If rural, give location) <i>21229</i>			
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED (NEVER MARRIED) <i>WIDOWED, DIVORCED (specify) SINGLE</i>	8. DATE OF BIRTH <i>6/23/96</i>	9. AGE (In years last birthday) <i>70</i>	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Baltimore</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		13. FATHER'S NAME <i>Samuel Waters</i>		14. MOTHER'S MAIDEN NAME <i>Emma (Hinson) (Hinson)</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>215071011A</i>		17. INFORMANT ADDRESS <i>Mrs. Kathryn L. Clowney 5145 Stafford Rd.</i>	
18. <i>420.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH <i>Acute Myocardial Infarction 7</i> <i>ASCD. AS Coronary artery disease</i> <i>VENT. Fibrillation</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>YES</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <i>—</i>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <i>—</i>	
22. I certify that (I) (this hospital) attended the deceased from <i>4/11/67</i> 19 to <i>4/18/67</i> 19, that (I) was <i>did</i> saw the deceased alive on <i>4/18/67</i> 19 and that in (my) four opinion death occurred on the date and hour and from the causes stated above. (I) do <i>did</i> (did not) view the body after death.					
23A. SIGNATURE <i>B J Baldwin MD</i> M.D.				23B. DATE SIGNED <i>4/18/67</i>	
23C. PHYSICIAN'S NAME (Type) <i>B J Baldwin</i> M.D.				23D. ADDRESS <i>Maryland Gen Hosp</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>4/22/67</i>		24C. NAME OF CEMETERY or CREMATORY <i>BALTIMORE CEM.</i>	
24D. LOCATION <i>BALTO CITY MD</i>		24E. (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <i>APR 24 1967</i>		25B. NAME OF REGISTRAR <i>E. S. Mac Nabb</i>		25C. FUNERAL DIRECTOR ADDRESS <i>301 Frederick Rd Balt 28 Md</i>	



BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JOHN JOSEPH DOMBROSKY

2. DATE AND HOUR PRONOUNCED DEAD

4-19-67

10:25 AM

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

2626 N. CALVERT STREET - Amb. Crew #3

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2626 N. Calvert Street 21218

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

August 12 1946

9. AGE (in years
last birthday)

20

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Worker for Baltimore City

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Cumberland Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Eugene F. Dombrosky Deceased.

14. MOTHER'S MAIDEN NAME

Margaret Hannon

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

Mrs. Margaret Dombrosky.

ADDRESS

8007 Delhaven Road Baltimore Md.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Hemorrhagic pulmonary edema
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) Aspiration of gastric contents
DUE TO

(C) Intoxication with barbiturates and Mellaril

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

Home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

2626 N. Calvert Street

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
4 19 '67 ?

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒21F. HOW DID INJURY OCCUR? Ingested overdose
of barbiturates and Mellaril

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☒

DATE SIGNED

ACTUAL
SIGNATURE

RUSSELL S. FISHER, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

4-19-67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

4/22/67

23C. NAME OF CEMETERY or CREMATORY

St. Patricks Cem

23D. LOCATION

(City, town, or county)

(State)

Cumberland Md.

24A. DATE REC'D BY HEALTH DEPT.

APR 24 1967

24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

Louis Stein Inc. Cumberland Md.

ADDRESS

August 12 1946

Single

U.S.A.

Cambridge, Mass.

Warner for Baltimore City

Harvard University

Harvard University

Harvard University

Harvard University

to

101

Cambridge, Mass.

U.S. Library of Congress

Library

Library

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 4013		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 67 4013	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) HARRY A. FEY SR.				4-22-67 2:00 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 37 Mercy Hosp.				A. STATE B. COUNTY MD. Balto			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 3-02			
				D. STREET ADDRESS (If rural, give location) 811 E. Baltimore St.			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) W	8. DATE OF BIRTH 2-14-91	9. AGE (In years last birthday) 76	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PRINTER CUNEO EASTERN PRESS			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Philadelphia Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Oscar Fey			14. MOTHER'S MAIDEN NAME Anna Howard				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS MR. H.A. FEY, JR. 309 HIGHLAND LA, FEY BRYN MAWR, PENNA.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g. heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) E916.41-163X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Gr. Septicemic Shock Burns 2° & 3° of foot & leg 1 day 3 wks				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO Gr. Septicemic Shock Burns 2° & 3° of foot & leg 1 day 3 wks			
19. DATE OF OPERATION 4-18-67				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Debridement		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 811 E. Baltimore St.	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 4 8 67				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? lit a box of matches	
22. I certify that (I) (this hospital) attended the deceased from 4-10-67 19 to 4-22-67 19, that (I) (we) last saw the deceased alive on 4-22-67 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Herbert J. Witmann				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 4-22-67	
23C. PHYSICIAN'S NAME HERBERT J. WITMANN				23D. ADDRESS Mercy Hosp.			
24A. BURIAL CREMATION, REMOVAL (Specify) CREMATION		24B. DATE 4/22/67		24C. NAME OF CEMETERY OR CREMATORY GREENMOUNT		24D. LOCATION (City, town, or county) (State) BALTIMORE, MD.	
25A. DATE APR 24 1967		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR H. W. MEARS & SON		ADDRESS 805 N. CALVERT ST.	

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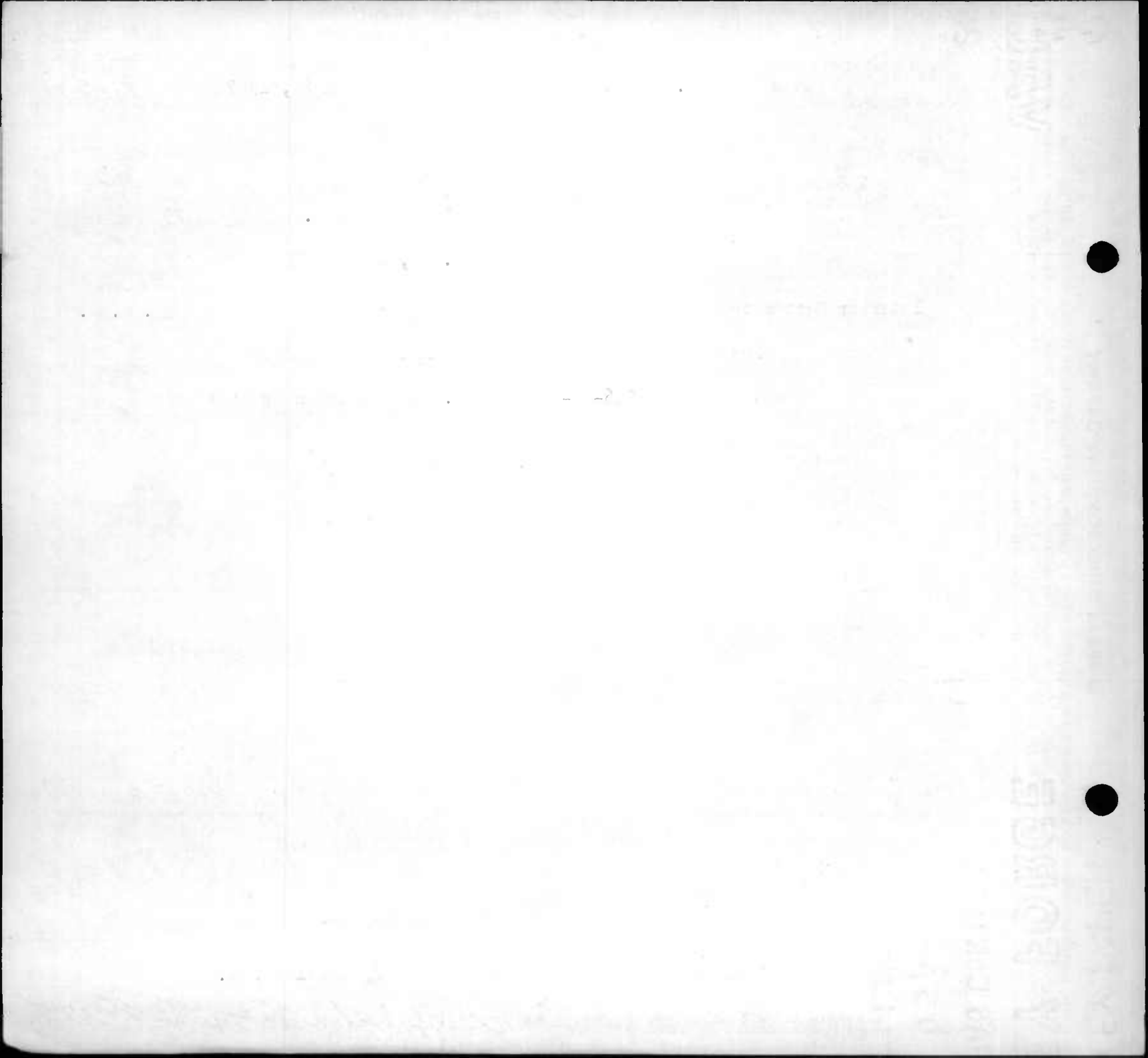
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 4014</u>	
BIRTH NO. <u>67 4014</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Otto W. Gauger</u>			
2. DATE AND HOUR OF DEATH <u>April 23, 1967</u> <u>9:15 A.M.</u>		3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>2 Benkert Avenue</u> <u>Baltimore, Maryland</u> <u>21229</u>			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>		5. SEX <u>Male</u> 6. RACE <u>White</u> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Widowed</u>			
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>		8. DATE OF BIRTH <u>Jan. 24, 1878</u> 9. AGE (In years last birthday) <u>89</u>			
D. STREET ADDRESS (If rural, give location) <u>2 Benkert Ave.</u> <u>29</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Interior Decorator</u>			
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>George Frederick Gauger</u>		14. MOTHER'S MAIDEN NAME <u>Marie Dodderer</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> <u>None</u>		16. SOCIAL SECURITY NO. <u>216-03-9839</u>		17. INFORMANT ADDRESS <u>Mrs. William Isern same address</u>	
18. <u>422.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>arteriosclerotic Cardio-Vascular Disease</u>		INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Dec 14, 1961</u> to <u>Apr 23, 1967</u> , that (I) (we) last saw the deceased alive on <u>Apr 22, 1967</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>[Signature]</u>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>4-24-67</u>	
23C. PHYSICIAN'S NAME (Type) <u>HARRY L. KNIPP, M.D.</u>		23D. ADDRESS <u>4116 Edmondson Ave Balto, Md 21229</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/26/1967</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Woodlawn, Md</u>		25A. DATE REC'D BY HEALTH DEPT. <u>APR 24 1967</u>			
25B. NAME OF REGISTRAR <u>Robert E. Fickens</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Wm J. Fickens & Sons 1301 N. E. St. Balto, Md.</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 4015	
CERTIFICATE OF DEATH					
BIRTH NO. 67 4015					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) <i>MARION Gift LANG</i>		2. DATE AND HOUR OF DEATH <i>4/23/67 7:15 A.M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived; if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Union Mem Hosp</i>		A. STATE <i>MD</i> B. COUNTY <i>Balt</i> City <i>Balt</i>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Balt</i>			
		D. STREET ADDRESS (If rural, give location) <i>12-01</i>			
5. SEX <i>F</i>	6. RACE <i>Cauc.</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, SPECIFY <i>Widow</i>	8. DATE OF BIRTH <i>5/22/99</i>	9. AGE (In years last birthday) <i>67</i>	10. If Under 1 Yr. Months Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Penn</i>	
12. CITIZEN OF WHAT COUNTRY? <i>US</i>		13. FATHER'S NAME <i>Foster U. Jeff</i>			
14. MOTHER'S MAIDEN NAME <i>Carrie Swengle</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			
16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Union Memorial Hospital Records</i>			
18. <i>241X I</i>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) <i>Pulmonary Embolism</i>			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(B) <i>Heart Strain</i>			
ANTECEDENT CAUSES		(C) <i>Bronchial Asthma</i>			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>4/22/67</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>Yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <input type="checkbox"/>	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED	
21F. HOW DID INJURY OCCUR?		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify, that (I) (this hospital) attended the deceased from <i>4/22/67</i> to <i>4/23/67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (and not) view the body after death.					
23A. SIGNATURE <i>Robert P. Doyle</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>4/22/67</i>	
23C. PHYSICIAN'S NAME (Type) <i>DR. ROBERT P. DOYLE</i>		23D. ADDRESS <i>THE UNION MEMORIAL HOSPITAL</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>4/25/1967</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Greenmount Cemetery</i>	
24D. LOCATION (City, town, or county) <i>Baltimore, Maryland</i>		24E. (State) <i>Baltimore, Maryland</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>APR 24 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>Wm. F. Fickner</i>	
Address <i>Baltimore, Md.</i>		Address <i>Baltimore, Md.</i>			

ADMISSION TICKET

Robert A. Doyle
Robert A. Doyle

1/15/19

1/15

1/15/19
1/15/19
1/15/19

Robert A. Doyle
Robert A. Doyle

Robert A. Doyle

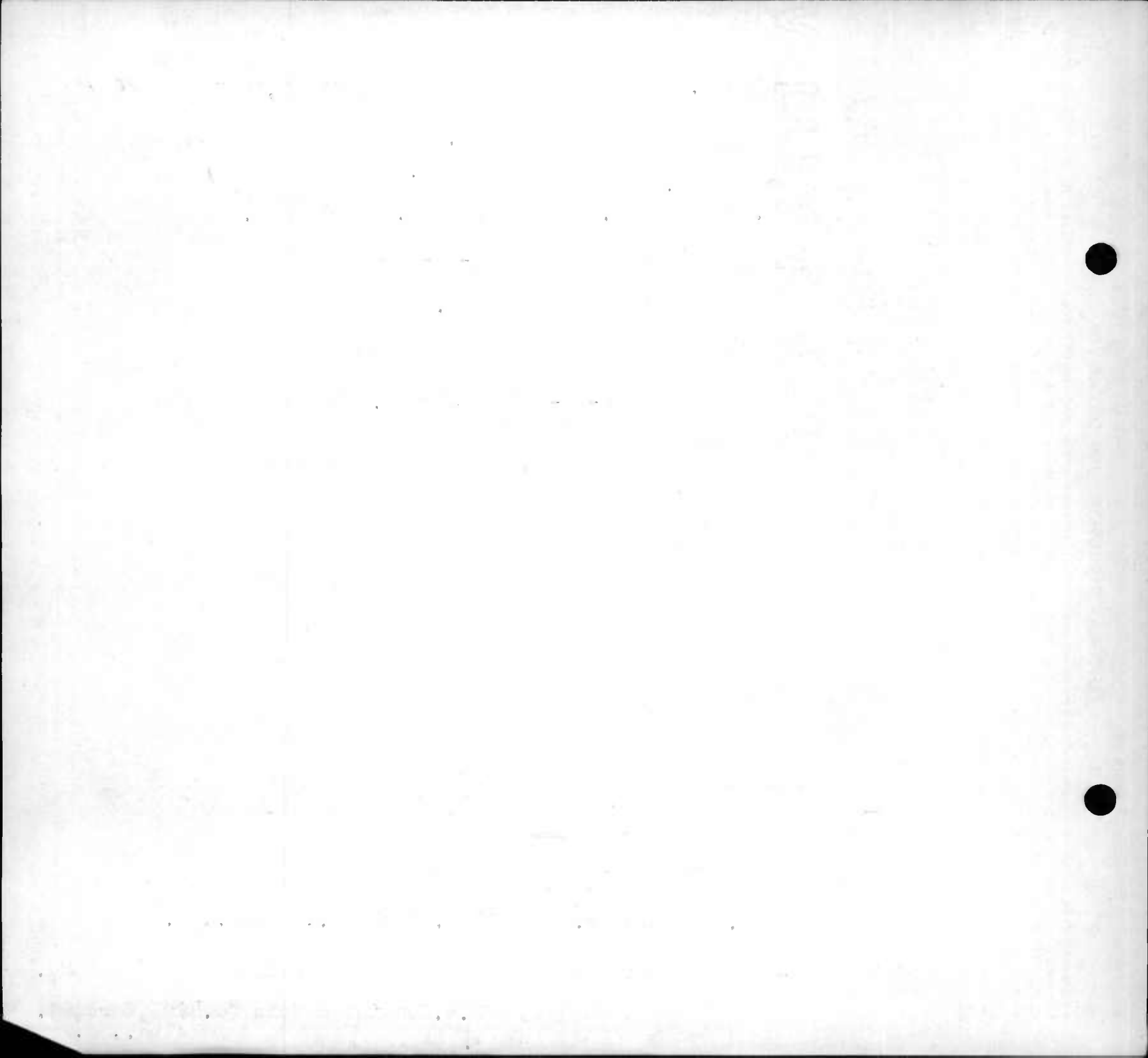
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

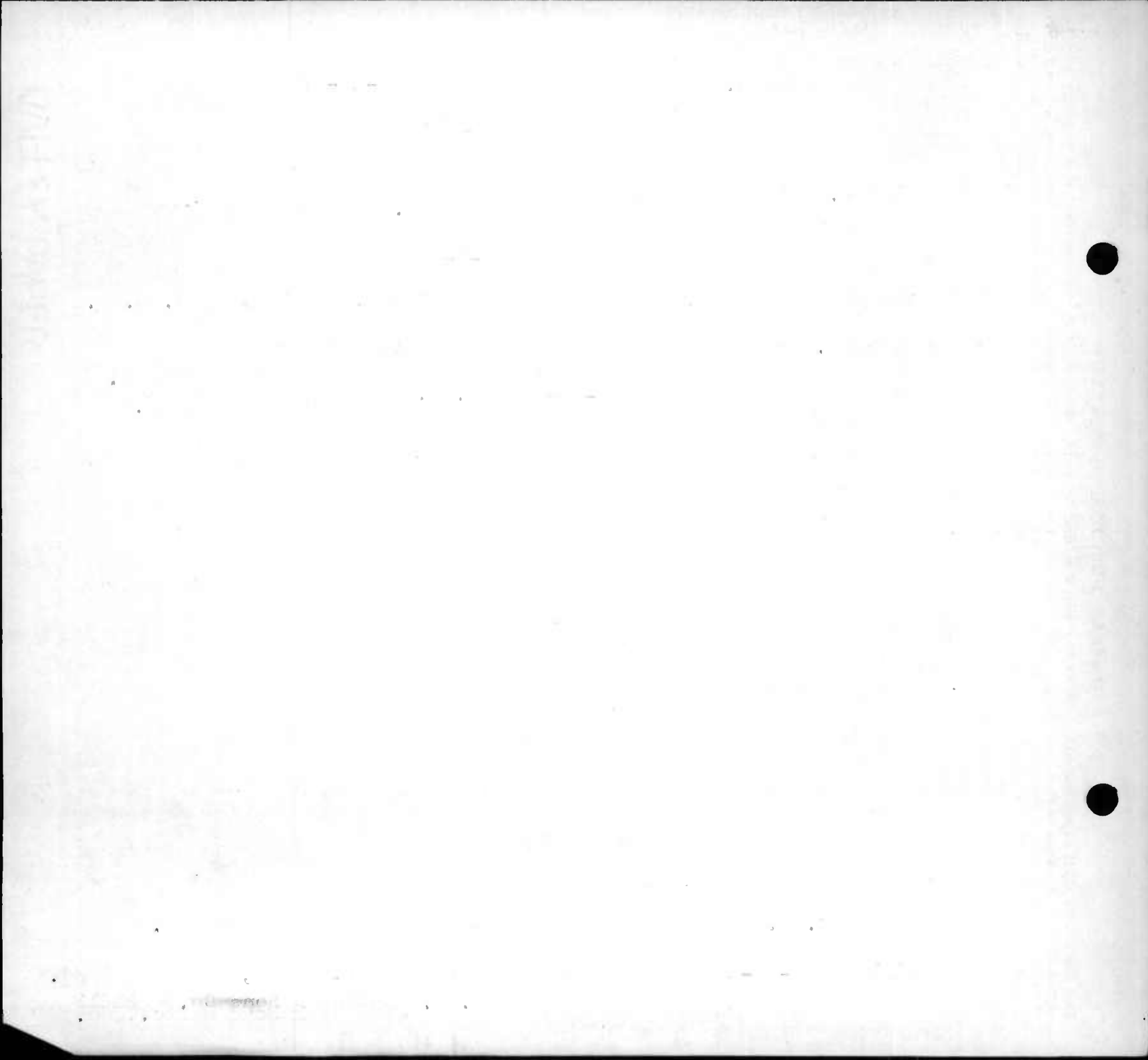
BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. 67 4016		67 4016		67 4016	
CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Louise W. Lockard		April 21, 1967 10 P. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Homewood Apts. 3003 N. Charles St.		A. STATE Md. B. COUNTY Balto.			
5. SEX F		6. RACE W		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH	
Housewife		Own Home		4-19-1882 85	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		9. AGE (In years last birthday)	
John Randolph Wright		Mary Thompson		11. BIRTHPLACE (State or foreign country)	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		12. CITIZEN OF WHAT COUNTRY?	
No		220-44-4030		Md. USA	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		19. CAUSE OF DEATH		20. INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO		2-yr.	
ANTECEDENT CAUSES		(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
(APPROX.)					
22. I certify that (I) (the hospital) attended the deceased from 10/9 1963 to 4/21 1967, that (I) (we) last saw the deceased alive on 4/18 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Norman R. Freeman Jr.				4/24/67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Norman R. Freeman Jr.				11 W. 29th St., Balto., Md.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		4-24-67		Druid Ridge	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
APR 24 1967		H.W. Jenkins & Sons Co.		4905 York Rd Balto., Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

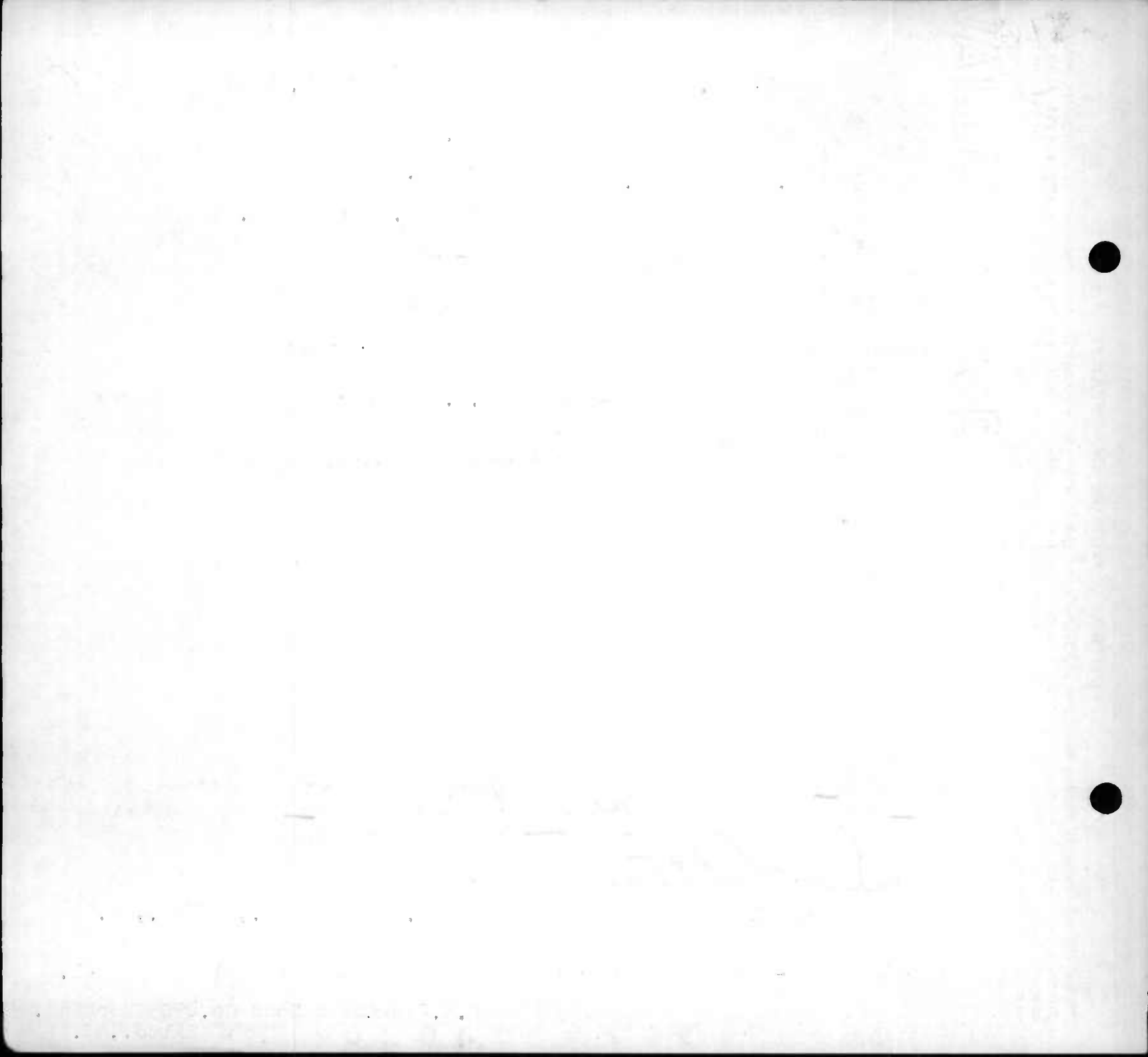
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				Registered No. <u>67 4017</u>	
BIRTH NO. <u>67 4017</u>		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Edna B. Goodwin</u>	
2. DATE AND HOUR OF DEATH <u>4-22-67</u>		3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>100 W. University Parkway</u>			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>		5. SEX <u>F</u> 6. RACE <u>W</u> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Widowed</u>			
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>		8. DATE OF BIRTH <u>9-1-1890</u>		9. AGE (In years last birthday) <u>76</u>	
O. STREET ADDRESS (If rural, give location) <u>100 W. University Parkway</u>		10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Edward L. Bresee</u>	
14. MOTHER'S MAIDEN NAME <u>Abigail Pinigree</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no, unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-28-4699</u>	
17. INFORMANT <u>13 South St. Mercantile Safe Deposit & Trust Co.</u>		18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Arteriosclerotic Heart Disease 10 years</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>None</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>None</u>			
19A. DATE OF OPERATION <u>None</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>December 19 65</u> to <u>April 22 19 67</u> , that (I) (we) last saw the deceased alive on <u>April 18 19 67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
23A. SIGNATURE <u>L. Myrton Gaines</u>		M.D. <input checked="" type="checkbox"/> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>April 24, 1967</u>	
23C. PHYSICIAN'S NAME (Type) <u>Dr. L. Myrton Gaines</u>		23D. ADDRESS <u>7800 York Road Towson, Md.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4-25-67</u>		24C. NAME OF CEMETERY or CREMATORY <u>Greenmount Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>APR 24 1967</u>			
25B. NAME OF REGISTRAR <u>R. E. Farley</u>		25C. FUNERAL DIRECTOR <u>H. W. Jenkins & Sons Co.</u>			
ADDRESS <u>4905 York Road Balto., Md.</u>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 4018	
BIRTH NO. 67 4018		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Stella G. Cleaver		2. DATE AND HOUR OF DEATH April 23, 1967 3⁰⁰ P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Balto.			
FULL NAME OF HOSPITAL OR INSTITUTION 3700 N. Charles St.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) 12-01		D. STREET ADDRESS (If rural, give location) 3700 N. Charles St.	
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 10-7-1902	9. AGE (In years lost birthday) 64	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Canada	
13. FATHER'S NAME Norris Esty		14. MOTHER'S MAIDEN NAME Wilkerson		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-46-7931		17. INFORMANT A.J. Cleaver	
				ADDRESS Above	
18. 42011 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Acute myocardial infarction DUE TO (B) Hypertension DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH 1952	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 1944 to February 21, 1967 , that (I) (we) last saw the deceased alive on Feb 21, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature]		M.D. <input type="checkbox"/> Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 4/24/67	
23C. PHYSICIAN'S NAME (Type) Samuel Whitehouse		23D. ADDRESS 3900 N. Charles St., Balto., Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-26-67		24C. NAME OF CEMETERY or CREMATORY Riverview	
		24D. LOCATION (City, town, or county) Wilmington Del.			
25A. DATE REC'D BY HEALTH DEPT. APR 24 1967		25B. NAME OF REGISTRAR Robert E. [Signature]		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd. Balto., Md.	



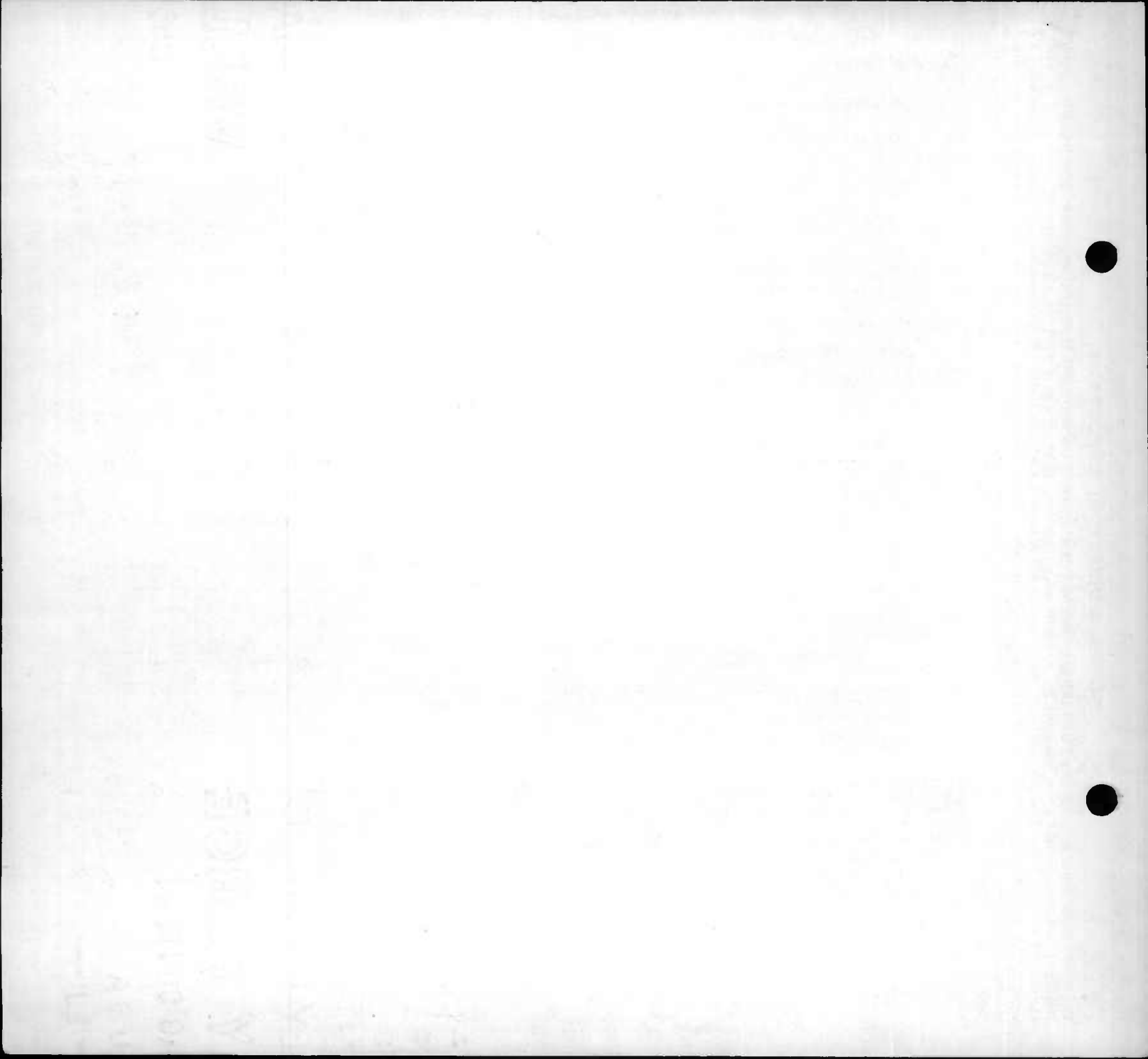
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

CERTIFICATE OF DEATH

Registered No.

67 4019

BIRTH NO. 67 4019		CERTIFICATE OF DEATH		Registered No. 67 4019	
M.E. CASE NO.		NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Georgie Conyer		April 20, 1967 4:20 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 00 1055 Ellicott Drive		A. STATE Maryland C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1055 Ellicott Drive			
5. SEX Female	6. RACE Colored	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH Aug 29, 1885	9. AGE (In years last birthday) 81	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10B. KIND OF BUSINESS OR INDUSTRY Private Family		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME John Hadrick		14. MOTHER'S MAIDEN NAME Cedellia Wilson		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Georgie Hammond 1055 Ellicott Drive	
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Myocardial Infarction DUE TO (B) Arteriosclerotic Heart Disease DUE TO (C) Hypertension		INTERVAL BETWEEN ONSET AND DEATH 3-4 minutes 5 years 5 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from April 1963 to April 20 1967 that (II) (we) last saw the deceased alive on April 15 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Samuel R. Owings, Jr.		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 4-21-67	
23C. PHYSICIAN'S NAME (Type) Samuel R. Owings Jr		23D. ADDRESS M.D. 909 N. Carey Street - Balto, Md 21217			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/24/67		24C. NAME of CEMETERY or CREMATORY Bryans Chapel Cemetery	
24A. DATE REC'D BY HEALTH DEPT. APR 24 1967		24B. NAME OF REGISTRAR R. E. E. E.		24C. FUNERAL DIRECTOR Herbert E. Nutter 3035 W. North Ave	
24D. LOCATION (City, town, or county) (State) Graysonville, Maryland					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 4020	
BIRTH NO. 67 4020		CERTIFICATE OF DEATH			
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) KENNEDY, MARCUS			4 - 22 - 67 5 A-M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION LUTHERAN HOSPITAL OF MARYLAND			A. STATE MARYLAND B. COUNTY		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE		
			D. STREET ADDRESS (If rural, give location) 1109. N. FULTON AVE		
5. SEX M	6. RACE C	7. MARRIED NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 8-18-04	9. AGE (In years last birthday) 62	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labourer		10B. KIND OF BUSINESS OR INDUSTRY H. Elapp & Co. Scrap Iron		11. BIRTHPLACE (State or foreign country) MARYLAND, Baltimore	
13. FATHER'S NAME Marcus Kennedy			12. CITIZEN OF WHAT COUNTRY? U. S. A		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 213-01-5898		17. INFORMANT LEATHIA PARRON.
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) Cardiac insufficiency Myocardial infarction ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH
MEDICAL CERTIFICATION					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4/13 19 67 to 4/22 19 67 , that (I) (we) lost saw the deceased alive on 4/22 19 67 and that in (my) (our) apinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Fernando Queral				23B. DATE SIGNED 4/22/67	
23C. PHYSICIAN'S NAME (Type) FERNANDO QUERAL				23D. ADDRESS Lutheran Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/26/67		24C. NAME OF CEMETERY or CREMATORY Paradise Cemetery	
24D. LOCATION Talbot County Maryland					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR Herbert E. Nutter-3035 W. North Ave.	
APR 24 1967		Herbert E. Nutter			

LUTHERAN HOSPITAL OF MARYLAND

MARRIED

C

M

LABORATORY

BALTIMORE

1101 N. Fulton Ave

8-12-24

MARYLAND

U.S.D.

LUTHERAN HOSPITAL

STATE

48-90-62

DH

A-535 67 4021

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

67 4021

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

John Aaron Anthony

2. DATE AND HOUR OF DEATH

4-22-67

8:25 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland #21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2325 N. Longwood St. #21216

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widower

8. DATE OF BIRTH

5-28-89

9. AGE (In years
lost birthday)

77

10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Red Cap Porter

10B. KIND OF BUSINESS OR INDUSTRY

Penna Railroad

11. BIRTHPLACE (State or foreign country)

Maryland, Baltimore

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

John Anthony

14. MOTHER'S MAIDEN NAME

Fannie Cunningham

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

717-07-7547 A

17. INFORMANT

BCH 4940 Eastern Avenue

RECORDS:

Baltimore, Maryland #21224

18. E900.0

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) DUE TO

Fracture of hip

(B) DUE TO

Pneumonia of lung

(C) DUE TO

"Septicemia"

INTERVAL BETWEEN
ONSET AND DEATH

3/18/67

4/22/67

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2 3/22/67

19B. CONDITION FOR WHICH OPERATION

WAS PERFORMED

F. G. M. S.

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

YES

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

HOME

21C. WHERE DID
INJURY OCCUR?

3325 N. Longwood St.

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

3-15-67 ?

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☒

21F. HOW DID INJURY OCCUR?

Fell down steps at home

22. I certify that (I) (this hospital) attended the deceased from

3/18/67

19

to

4/22/67

19

that (I) (we) last saw the deceased alive on

4/22/67

19

and that in (my) (our) opinion death occurred on the date

and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Victor Hernandez

M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

4/22/67

23C. PHYSICIAN'S
NAME (Type)

Victor Hernandez

M.D.

23D. ADDRESS

4940 Eastern Avenue Baltimore, Md. #21224

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

4/25/67

24C. NAME OF CEMETERY or CREMATORY

Mount Auburn Cemetery

24D. LOCATION

(City, town, or county)

Baltimore Maryland

(State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

APR 24 1967

Herbert E. Nutter

Herbert E. Nutter- 3035 W. North Ave.

VS 150-REV. 1/1/65

2010-9876004022

RELEASED ON APPROVAL BY THE MEDICAL EXAMINER 4-22-67 11:17 P.M.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH										Registered No. <u>67 4022</u>	
BIRTH NO. <u>67 4022</u>		M.E. CASE NO.									
1. NAME OF DECEASED (Type or Print) <u>THOMAS B. RICE</u>						2. DATE AND HOUR OF DEATH <u>4/18/67</u> <u>7</u> A.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>LUTHERAN HOSPITAL OF MARYLAND INC.</u>						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> D. STREET ADDRESS (If rural, give location) <u>2521 HARLEM AVE.</u>					
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>WID.</u>	8. DATE OF BIRTH <u>9/25/81</u>	9. AGE (In years last birthday) <u>85</u>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <u>Virginia</u>			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <u>Thomas Rice</u>						14. MOTHER'S MAIDEN NAME <u>Unknown</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>217-07-0063</u>			17. INFORMANT <u>Beatrice Rice</u>			ADDRESS <u>2521 Harlem Ave.</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <u>ACUTE GASTROENTERITIS</u>						INTERVAL BETWEEN ONSET AND DEATH <u>14 DAYS</u>					
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>VIRAL INFECTION</u>											
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>1) Pyelonephritis</u> <u>2) Cerebral Arteriosclerosis</u>											
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from <u>4/3</u> 19 <u>67</u> to <u>4/18</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4/18</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <u>Fernando Queral</u>								M.D. <input type="checkbox"/> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>4/18/67</u>	
23C. PHYSICIAN'S NAME (Type) <u>FERNANDO QUERAL</u>								23D. ADDRESS M.D. <u>730 ASHBURTON ST., BALTIMORE, MD.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>4/20/67</u>		24C. NAME of CEMETERY or CREMATORY <u>Ashburton Mem. Ch.</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore MD.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>APR 25 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>William J. Phillips</u>		ADDRESS <u>1727 N. Monmouth</u>					

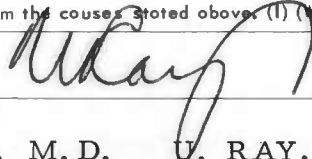
100

100



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 4023		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 67 4023	
1. NAME OF DECEASED (Type or Print) William F. Hughes			2. DATE AND HOUR OF DEATH April 15, 1967 M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2358 McCulloh Street			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2358 McCulloh Street		
5. SEX Male	6. RACE Colored	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Oct. 26, 1915	9. AGE (In years last birthday) 51	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Aaron H. Hughes			14. MOTHER'S MAIDEN NAME Maude Goodwin		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Frances Hughes ADDRESS 2358 McCulloh Street		
18. 443X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic and HCVD ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Cirrhosis of the liver associated with severe gastroduodenitis			INTERVAL BETWEEN ONSET AND DEATH One year		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. N/A					
19A. DATE OF OPERATION N/A		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED N/A		20A. AUTOPSY? (Yes or No) N/A	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) N/A		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) N/A		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? N/A	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) N/A		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? N/A	
22. I certify that (I) (this hospital) attended the deceased from May 11, 1965 to March 23, 1967 , that (I) (we) last saw the deceased alive on March 23, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (Yes) (did) (did not) view the body after death.					
23A. SIGNATURE 			M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED April 17, 1967
23C. PHYSICIAN'S NAME (Type) RAY, JR., M.D.			23D. ADDRESS U. RAY, JR. M.D. 2225 West North Avenue 21216		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-20-67	24C. NAME OF CEMETERY or CREMATORY Baltimore National		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland
25A. DATE REC'D BY HEALTH DEPT. APR 25 1967		25B. NAME OF REGISTRAR Robert E. Feltner		25C. FUNERAL DIRECTOR Arlington S. Phillips ADDRESS 1727 N. Monroe Street	

W. J. P. J.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

HAMMOND, BEVERLY D. LAURA

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)ST. AGNES HOSPITAL
WILKENS & CATON AVENUE
BALTIMORE 29, MARYLANDBALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

67 4024

2. DATE AND HOUR OF DEATH

APRIL 22, 1967

1:55 A.M.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

MARYLAND

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

ELLCOTT CITY

D. STREET ADDRESS (If rural, give location)

483 MAIN STREET

5. SEX
FEMALE6. RACE
NEGRO7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
MARRIED

8. DATE OF BIRTH

2-13-24

9. AGE (In years
last birthday)

43

If Under 1 Yr.

Months: Days: Hours: Min.

If Under 24 Hrs.

Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY

NONE

11. BIRTHPLACE (State or foreign country)

NORTH CAROLINA

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

UNKNOWN

14. MOTHER'S MAIDEN NAME

FRANCES DUNN

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

ST. AGNES HOSPITAL, WILKENS & CATON AVE

18. 590X I
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) DUE TO

(B) DUE TO

(C) DUE TO

INTERVAL BETWEEN
ONSET AND DEATHII
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Acute Glomerular nephritis.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
WorkNot While
At Work

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from MARCH 20 19 67 to APRIL 22 19 67,
that (I) (we) last saw the deceased alive on APRIL 22 19 67 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

M.D.

Attending
Phys.Med.
DirectorStaff
Phys.

23B. DATE SIGNED

APRIL 22, 1967

23C. PHYSICIAN'S
NAME (Type)

DR. ALEX MEJIA

M.D.

23D. ADDRESS

ST. AGNES HOSPITAL, WILKENS & CATON AVE.

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

4-25-67

24C. NAME OF CEMETERY or CREMATORY

Baltimore National Cemetery

24D. LOCATION

(City, town, or county)

Baltimore, Maryland

(State)

25A. DATE REC'D BY HEALTH DEPT.

APR 25 1967

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

Arlington S. Phillips 1727 N. Monroe St

1967

APRIL 22, 1967

RECEIVED, DEPT. OF JUSTICE

ST. LOUIS, MISSOURI
APRIL 22, 1967
TO: DIRECTOR, FBI
FROM: SAC, ST. LOUIS
SUBJECT: [illegible]

ST. LOUIS, MISSOURI
APRIL 22, 1967
TO: DIRECTOR, FBI
FROM: SAC, ST. LOUIS
SUBJECT: [illegible]

U.S.A. [illegible]

HOUSE 100 [illegible]

UNKNOWN

ST. LOUIS, MISSOURI, APRIL 22, 1967

NO

OF

APRIL 22, 1967

RECEIVED

APRIL 22

APRIL 22, 1967

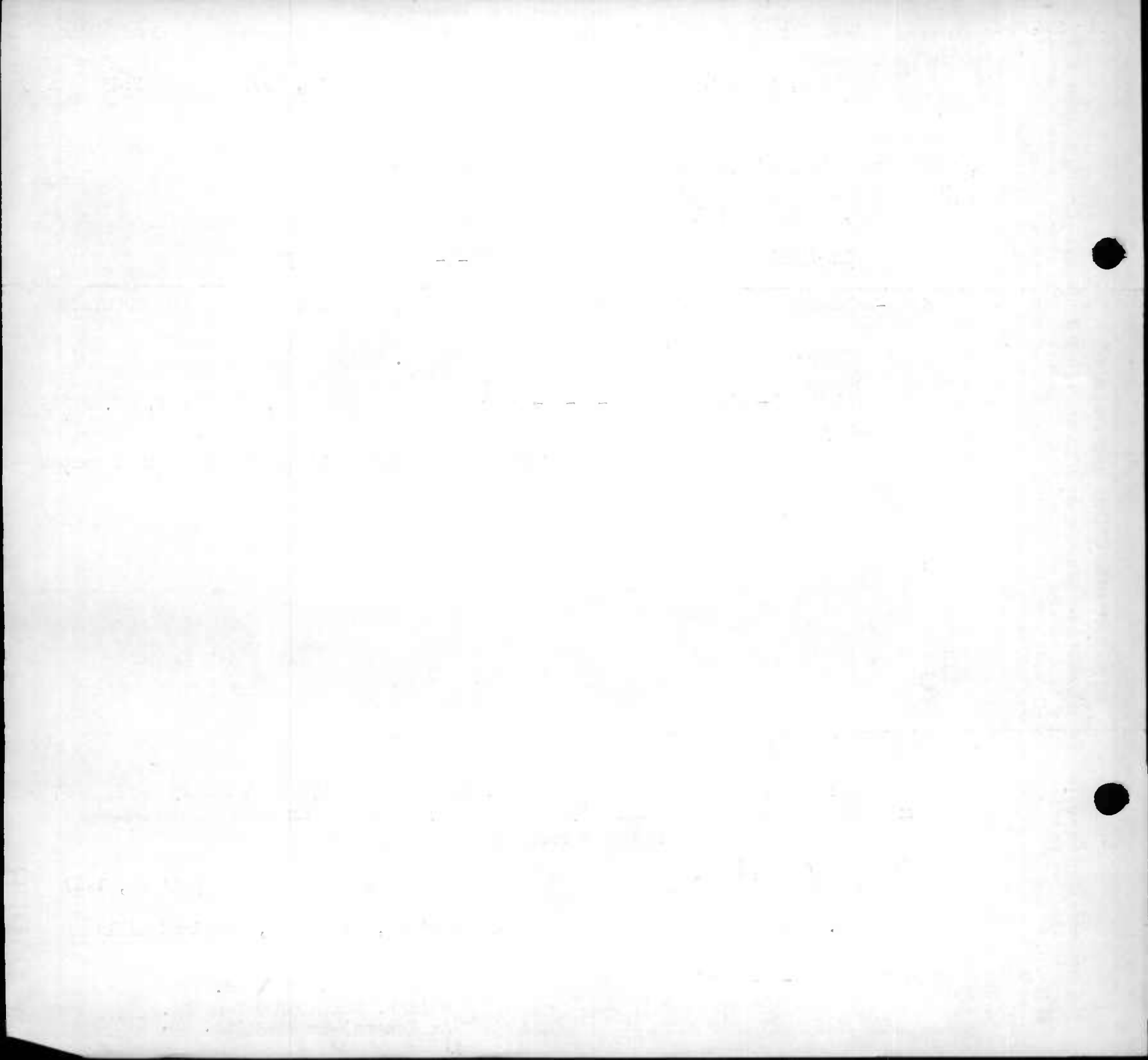
ST. LOUIS, MISSOURI, APRIL 22, 1967

RECEIVED

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. 67 4025		CERTIFICATE OF DEATH		67 4025	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) DUDDING, EVERETT KYLE		2. DATE AND HOUR OF DEATH APRIL 23, 1967 2:45 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) VETERANS ADMINISTRATION HOSPITAL 3900 LOCH RAVEN BOULEVARD BALTIMORE, MARYLAND 21218		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 643 MC KEWIN AVENUE			
5. SEX MALE	6. RACE CAUCASIAN	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 10-1-14	9. AGE (In years last birthday) 52	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Driver-Salesman		10B. KIND OF BUSINESS OR INDUSTRY National Brewery Co		11. BIRTHPLACE (State or foreign country) ROANOKE, VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? UNITED STATES					
13. FATHER'S NAME ORTIE DUDDING		14. MOTHER'S MAIDEN NAME NELLIE V. CRUSH			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES 11/18/43-2/15/46		16. SOCIAL SECURITY NO. 212-01-54-33		17. VA HOSPITAL RECORDS ADDRESS 3900 LOCH RAVEN BLVD, BALTIMORE, MD. 21218	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Metastatic bronchogenic Carcinoma		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH 3 to 4 months	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO			
		(B) DUE TO			
		(C) DUE TO			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that HE (this hospital) attended the deceased from APRIL 19 19 67 to APRIL 23 19 67 , that WE last saw the deceased alive on APRIL 23 19 67 and that in OUR (our) opinion death occurred on the date and hour and from the causes stated above. WE (We) (did) (did not) view the body after death.					
23A. SIGNATURE Allen D. Johnson				23B. DATE SIGNED April 24, 1967	
23C. PHYSICIAN'S NAME (Type) ALLEN D. JOHNSON		23D. ADDRESS VA Hospital, Baltimore, Maryland 21218			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-26-1967		24C. NAME OF CEMETERY or CREMATORY Baltimore National Cemetery Baltimore Md.	
24D. LOCATION (City, town, or county) (State)					
25A. DATE REC'D BY HEALTH DEPT. APR 25 1967		25B. NAME OF REGISTRAR Robert E. Seitz		25C. FUNERAL DIRECTOR Eugenia K. Seitz 5209 York Rd. Seitz Funeral Home Balto. Md. 21212	



49-10-18
NW

1W 252 67. 4026

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

67 4026

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67. 4026		M.E. CASE NO. RICHARD	
1. NAME OF DECEASED (Type or Print) Timothy A Wojnowski		2. DATE AND HOUR OF DEATH 4/22/67 12:30/P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 31 BALTIMORE CITY HOSPITALS 4940 Eastern Avenue Baltimore, Maryland 21224		A. STATE MARYLAND C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 443 N. LAKEWOOD AVENUE - 21224	
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) NEVER MARRIED	8. DATE OF BIRTH 11-18-42
9. AGE (In years lost birthday) 24		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) COIN COUNTER		10B. KIND OF BUSINESS OR INDUSTRY BANK	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOSEPH WOJNOWSKI		14. MOTHER'S MAIDEN NAME HELEN PIASKOWSKI	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 1960-1963		16. SOCIAL SECURITY NO. 214-40-8846	
17. INFORMANT RECORDS: BCH, 4940 Eastern Ave., Balto. Md. 21224		ADDRESS	
18. 322.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH Alcoholic myocarditis	
ANTECEDENT CAUSES		INTERVAL BETWEEN ONSET AND DEATH 7 weeks	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) Myocarditis (B) Chronic Alcoholic (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Starvation			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 3/18/67 to 4/22/67 that (I) (we) last saw the deceased alive on 4/22/67 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE William A. Emerson		23B. DATE SIGNED 4/22/67	
23C. PHYSICIAN'S NAME (Type or Print) WILLIAM A. EMERSON		23D. ADDRESS BALTIMORE CITY HOSPITALS 4940 Eastern Avenue, Baltimore, Md. 21224	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4/26/67	
24C. NAME OF CEMETERY OR CREMATORY HOLY ROSARY CEM.		24D. LOCATION (City, town, or county) (State) BALTO. COUNTY, MD.	
25A. DATE REC'D BY HEALTH DEPT. APR 25 1967		25B. NAME OF REGISTRAR Robert E. Fialkowski	
25C. FUNERAL DIRECTOR Wm. Fialkowski		ADDRESS 2007 EASTERN AVE. BALTO. MD. 21231	

JOHN COWART BANK
BUSINESS

PIASKOWSKI

Yes 176-1963 5/4-45-50

BURIAL 4/10/63 1st County Cem. Barto County, Mo.
WINTERKOWSKI 2nd Eastern Ave.
BARTO 100 11-21

4/10/63 3/15/63

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 1B-356 67 4027		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 67 4027	
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) Ada Buddemeyer			April 22, 1967 M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 22 S. Athol Ave.			A. STATE Md. B. COUNTY		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		
			D. STREET ADDRESS (If rural, give location) 22 S. Athol Ave.		
5. SEX F	6. RACE Cauc.	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH Sept. 2/85	9. AGE (In years last birthday) 81	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Balto., Md.	
13. FATHER'S NAME Wm. F. Buddemeyer		14. MOTHER'S MAIDEN NAME Louise ---		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-26-9087		17. INFORMANT Gen. German Aged Home 22 S. Athol Ave.	
18. 420.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) Acute Cardiac Arrhythmia Arteriosclerotic heart disease Generalized Arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 1966 to 22 April 1967 that (I) (we) last saw the deceased alive on 22 April 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE William J. Bryson			23B. DATE SIGNED 23 April 67		
23C. PHYSICIAN'S NAME (Type) William J. Bryson			23D. ADDRESS 4605 Edmondson Ave.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-25-67		24C. NAME OF CEMETERY or CREMATORY Oaklawn Cem.	
24D. LOCATION Baltimore, Md.					
25A. DATE REC'D BY HEALTH DEPT. APR 25 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Witzke F. D. 4101 Edmondson Ave.	

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BIRTH NO. **67 4028** MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. **67 4028**

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) SUSANNA WALLACE				2. DATE AND HOUR PRONOUNCED DEAD April 8, 1967 8:30 P M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 43 South Baltimore General Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore			
5. SEX Female				6. RACE Negro		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	
8. DATE OF BIRTH 6-15-25				9. AGE (In years last birthday) 41		10. Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Va.	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME Henry Wallace			
14. MOTHER'S MAIDEN NAME Wallace ?				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT Ben Sachs -714 S. Hanover Street			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Carbon Monoxide Intoxication.				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Arteriosclerotic Cardiovascular Disease.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 716 S. Hanover Street		22-01	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 4 8 '67 P		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? House fire.			
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Charles S. Petty				CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
DATE SIGNED 4/9/67							
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 4/14/67		23C. NAME OF CEMETERY or CREMATORY Mt Auburn		23D. LOCATION (City, town, or county) (State) Baltimore City	
24A. DATE REC'D BY HEALTH DEPT. APR 25 1967		24B. NAME OF REGISTRAR Robert E. Fisher		24C. FUNERAL DIRECTOR Isaac S. Brown & Son		ADDRESS 108 W. Montgomery St.	

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 4029	
CERTIFICATE OF DEATH					
BIRTH NO. 67 4029		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) Joseph C. Liberto			2. DATE AND HOUR OF DEATH 4-17-67,		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 36 Franklin Square Hospital Baltimore, Md.			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		
			D. STREET ADDRESS (If rural, give location) 1031 W. Baltimore St.		
5. SEX M	6. RACE Sauc.	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Oct 2/94	9. AGE (In years last birthday) 68 72	If Under 1 Yr. Months: Days If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Produce Merchant		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Balto., Md.	
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Late- Pasquale Liberto			14. MOTHER'S MAIDEN NAME Late - Maria ---		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Anna Liberto 1031 W. Baltimore St.	
18. 522711 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Polmonary Edema ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Polmonary Emphysema - Hypertensive Cardio-Ves. Disease		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 2 days. years. " "	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1963 - 19 to 4/6/67 - 19, that (I) (we) last saw the deceased alive on 4/6/67 - 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Charles J. Tommasello				23B. DATE SIGNED Apr. 20/67 -	
23C. PHYSICIAN'S NAME (Type) Charles J. Tommasello				23D. ADDRESS 910 W. Lombard St.	
24A. BURIAL CREMATION, REMOVAL (Specify) 4-24-67-Burial		24B. DATE		24C. NAME OF CEMETERY or CREMATORY New Cathedral Cem.	
24D. LOCATION (City, town, or county) (State) Balto., Md.					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR Witzke F. D.		25C. FUNERAL DIRECTOR ADDRESS 4101 Edmondson Ave.	

Joseph J. ...

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Franklin ...

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 4030	
BIRTH NO. 67 4030				CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Ellen M. Hudlin			
2. DATE AND HOUR OF DEATH April 22, 1967		M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION 608 Stanford Rd.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
D. STREET ADDRESS (If rural, give location) 608 Stanford Rd.		28-04			
5. SEX F	6. RACE Cauc.	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 2-22-80	9. AGE (In years last birthday) 87	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Peter McKeowne		14. MOTHER'S MAIDEN NAME Ellen Blanchard	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mary Ellen Hudlin 608 Stanford Rd.	
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Coronary occlusion instant Cardiovascular Dis. 5 years		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO		(B) DUE TO	
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from April 22 19 67 to 4/22 19 67 . that (I) (we) lost saw the deceased alive on 4/22 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE Christian S. Mass M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>	
23B. DATE SIGNED 4/24/67		23C. PHYSICIAN'S NAME (Type) Christian S. Mass		23D. ADDRESS M.D. Balto. Nat'l. Pike & St. John's Lane	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 26 Apr. 67		24C. NAME of CEMETERY or CREMATORY New Cathedral Cem.	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. APR 25 1967		25B. NAME OF REGISTRAR Robert E. Johnson	
25C. FUNERAL DIRECTOR Witzke F. D. - 4101 Edmondson Ave.		ADDRESS			

William A. Martin

August 1, 1951

Dear Mr. Martin:

Thank you for your letter of July 27, 1951.

Yours,

W

William A. Martin

William A. Martin

Dear Mr. Martin:

Dear Mr. Martin:

Very truly yours,
W. A. Martin

William A. Martin, 1111 1st St., N.W., Washington, D.C.

William A. Martin, 1111 1st St., N.W., Washington, D.C.

Washington, D.C.

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Washington, D.C.

William A. Martin, 1111 1st St., N.W., Washington, D.C.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 4031		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 4031	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) PETER SINKIEWICZ (Cyncoski)			2. DATE AND HOUR OF DEATH April 23, 1967 5-07 M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 Gould Convalesarium			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 219 S. Grundy Street		
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH June 5, 1895	9. AGE (In years last birthday) 71	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Inspector		10B. KIND OF BUSINESS OR INDUSTRY American Smelting	11. BIRTHPLACE (State or foreign country) Warsaw, Poland		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Thomas Sinkiewicz			14. MOTHER'S MAIDEN NAME Catherine		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-10-1714	17. INFORMANT ADDRESS Mrs. Catherine Mills 516 N. East Avenue		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 156.1 I CAUSE OF DEATH (A) Cerebral Thrombosis (B) DUE TO (C) INTERVAL BETWEEN ONSET AND DEATH					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4/21 1967 to 4/23 1967 that (I) (we) last saw the deceased alive on 4/21 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>J. H. Goodman</i>			M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 4/25/67
23C. PHYSICIAN'S NAME (Type) J. H. Goodman			23D. ADDRESS 3460 E. Balto St Balto Md		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-26-1967		24C. NAME OF CEMETERY or CREMATORY Gardens of Faith	
24D. LOCATION (City, town, or county) (State) Baltimore County, Maryland		25A. DATE REC'D BY HEALTH DEPT.			
25B. NAME OF REGISTRAR APR 25 1967		25C. FUNERAL DIRECTOR ADDRESS Lilly & Zeiler Inc. 1901-07 Eastern Ave.			

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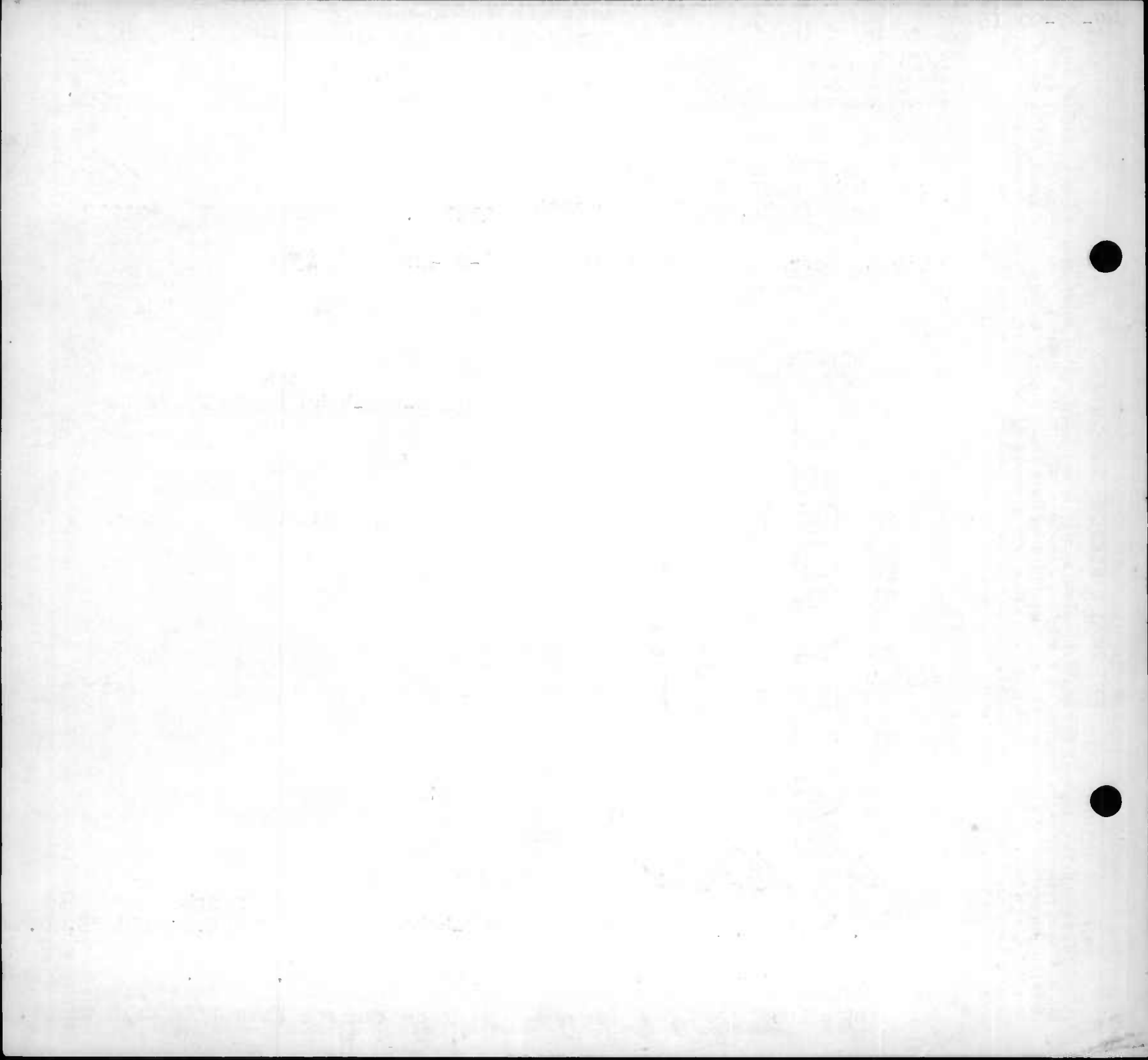
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FUNERAL DIRECTOR: IMPORTANT

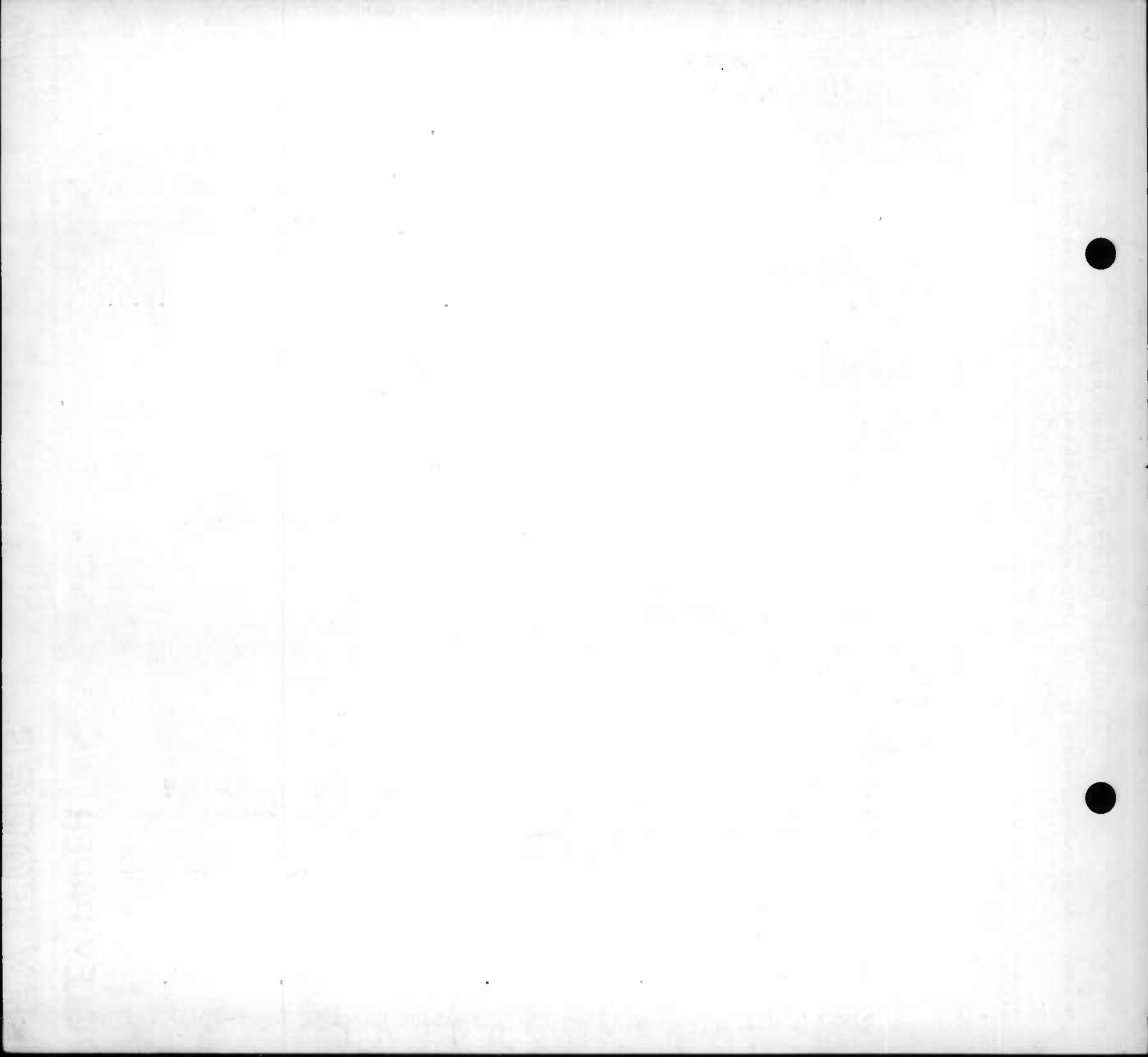
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 4032		BALTIMORE CITY HEALTH DEPARTMENT	
M.E. CASE NO.		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Willie Mark ANDERSON		2. DATE AND HOUR OF DEATH 4-19-67 8:25 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 31 BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND #21224		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1361 N. STRICKER STREET #21217	
5. SEX male	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Separated	8. DATE OF BIRTH 3-20-22
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 45
11. BIRTHPLACE (State or foreign country) SOUTH CAROLINA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME WILLIE Anderson		14. MOTHER'S MAIDEN NAME CECILA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT #21224 ADDRESS RECORDS-BCH-4940 EASTERN AVENUE
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 3-21-11 Lannaec's Cirrhosis ANTECEDENT CAUSES Chronic Alcoholism DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) DUE TO Lannaec's Cirrhosis (B) DUE TO Chronic Alcoholism (C) INTERVAL BETWEEN ONSET AND DEATH Years 25 years	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) YES
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 3-31 19 67 to 4-19 19 67, that (I) (was) last saw the deceased alive on 4-19 19 67 and that in (my) (own) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
23A. SIGNATURE David J. Mishelevich		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	23B. DATE SIGNED 4-19-67
23C. PHYSICIAN'S NAME (Type) DR. DAVID J. MISHELEVICH		23D. ADDRESS #21224 BCH-4940 EASTERN AVENUE, BALTIMORE, MD.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 4-25-67	24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cemetery	24D. LOCATION (City, town, or county) (State) Balto. Md.
25A. DATE REC'D BY HEALTH DEPT. APR 25 1967	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR Kelson Funeral Home 1348 Calhoun St.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 4033		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 4033	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Allen</i> <i>Henrietta v Bellamy</i>		2. DATE AND HOUR OF DEATH <i>4-19-67</i> <i>6:17 P.M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>37 Mercy Hospital</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Balto.</i> D. STREET ADDRESS (If rural, give location) <i>3615 Fairview Avenue</i>			
5. SEX <i>Female</i>	6. RACE <i>Negro</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>widowed</i>	8. DATE OF BIRTH <i>4-2-00</i>	9. AGE (In years last birthday) <i>67</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Va.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Robert Allen</i>			14. MOTHER'S MAIDEN NAME <i>Martha</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <i>Nannie Williams 3326 Brighton St.</i>		
18. <i>420.11</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) <i>Acute Myocardial Infarction</i> DUE TO (B) <i>Atherosclerotic Cardiovascular Disease</i> DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <i>7-5 days</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>YES</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that EB (this hospital) attended the deceased from <i>April 18th</i> 19 <i>67</i> to <i>April 19th</i> 19 <i>67</i> , that (I) last last saw the deceased alive on <i>April 19th</i> 19 <i>67</i> and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) was (did) (did not) view the body after death.					
23A. SIGNATURE <i>Raymond E. Knowles, Jr.</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>4-20-67</i>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>4-24-67</i>		24C. NAME OF CEMETERY or CREMATORY <i>Mt. Auburn Cem.</i>	
24D. LOCATION (City, town, or county) (State) <i>Balto. Md.</i>		25A. DATE REC'D BY HEALTH DEPT.			
25B. NAME OF REGISTRAR <i>APR 25 1967</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Nelson Funeral Home-1348 Calhoun St.</i>			



C-532

BIRTH NO. 67 4034 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 4034

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) CHARLES COUNTESS 2. DATE AND HOUR PRONOUNCED DEAD April 21, 1967 8:45 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY

CERTIFICATE AMENDED
PROVIDENT HOSPITAL (DOA) 5-11-67

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

D. STREET ADDRESS (If rural, give location) 1926 Brunt St.

5. SEX Male 6. RACE Negro 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Mar.-Sep 8. DATE OF BIRTH 9-17-36 9. AGE (In years last birthday) 30

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10B. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Md. 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Anglin Talbert 14. MOTHER'S MAIDEN NAME Edith Countess

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 213322464 17. INFORMANT ADDRESS Edith Countess 2112 Division St.

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Acute intoxication by ethanol and Paraldehyde

ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 2 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) Yes 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 1212 Division St. 17-02

21D. TIME OF INJURY (APPROX.) 4-21-67 21E. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21F. HOW DID INJURY OCCUR? Subject drank ethanol and paraldehyde

22. I certify that I held on Inquiry Inspection Autopsy and that on this basis, death in my opinion resulted from: Natural causes Accident Suicide Homicide Undetermined manner CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER EXAMINER'S NAME (Type) Charles S. Springate, M.D. ASSOCIATE MEDICAL EXAMINER DATE SIGNED 4-22-67

23A. BURIAL CREMATION, REMOVAL (Specify) Burial 23B. DATE 4-26-67 23C. NAME OF CEMETERY or CREMATORY Arbutus Mem. Pk. 23D. LOCATION (City, town, or county) (State) Arbutus Maryland

24A. DATE REC'D BY HEALTH DEPT. 24B. NAME OF REGISTRAR 24C. FUNERAL DIRECTOR ADDRESS Kelson Funeral Home 1348 Calhoun St.

APR 25 1967 67 4034

Letter from M.E.'s office

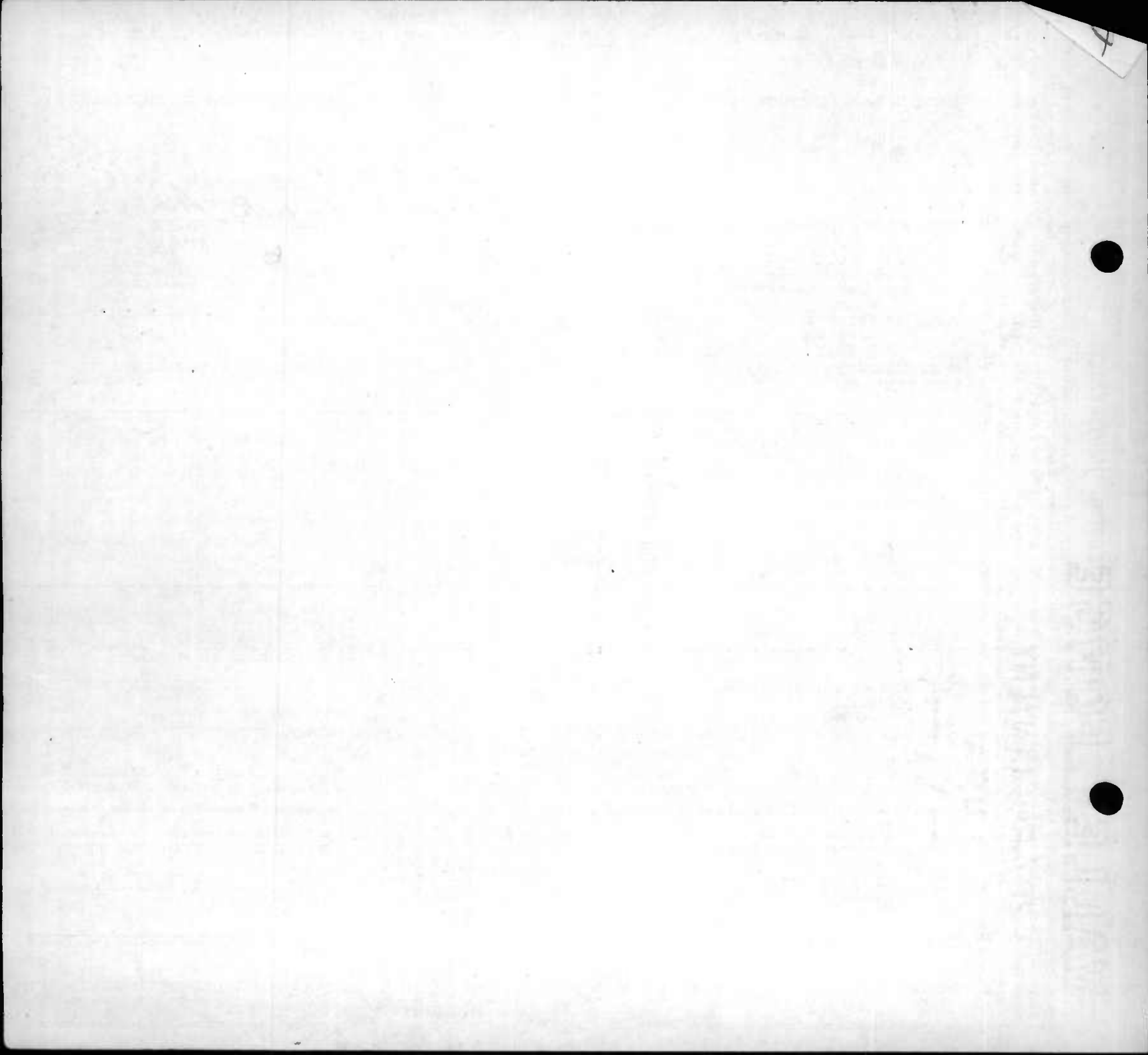
5-11-67

M.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 4035		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 4035	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) JAMES DARGAN		2. DATE AND HOUR OF DEATH 4/19/67 6 45 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION 46 LUTHERAN HOSPITAL		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
		D. STREET ADDRESS (If rural, give location) 1724 Lafayette Avenue			
5. SEX MALE	6. RACE COLORED	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) NEVER MARRIED	8. DATE OF BIRTH 3-8-31	9. AGE (In years last birthday) 36	10. Under 1 Yr. Months Days Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Rev. Ruffus Dargan		14. MOTHER'S MAIDEN NAME Mary Daniels	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. D.		17. INFORMANT Rev. Ruffus Dargan 1161 Mount Street	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g. heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 581.0 I Fatty degeneration of liver.		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		19. MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4/19 19 67 to 4/19 19 67, that (I) (we) last saw the deceased alive on 4/19 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Oscar E. Fernandez		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 4/19/67	
23C. PHYSICIAN'S NAME (Type) OSCAR E. FERNANDIN		23D. ADDRESS Lutheran Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-22-67		24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. Pk.	
		24D. LOCATION (City, town, or county) (State) Arbutus, Maryland			
25A. DATE REC'D BY HEALTH DEPT. APR 25 1967		25B. NAME OF REGISTRAR R. E. Fernandez		25C. FUNERAL DIRECTOR Kelson Funeral Home-1348 Calhoun St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 4036	
CERTIFICATE OF DEATH					
BIRTH NO. 536 67 4036					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) Ethel Eugenia Anderson			2. DATE AND HOUR OF DEATH Apr. 21, 1967 1 30 P. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland #21224			A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2035 N. Dukeland St. #21216		
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH 4-29-19	9. AGE (In years last birthday) 47	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Charles Anderson		14. MOTHER'S MAIDEN NAME Mary Mosely	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 217-22-4302		17. INFORMANT BCH 4940 Eastern Avenue RECORDS: Baltimore, Maryland #21224	
18. 204.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Chronic Lymphocytic Leukemia 1 1/2 y. E ? Sepsis			CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/30 19 67 to 4/21 19 67 , that (I) (we) last saw the deceased alive on 4/21 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Clayton Moravic M.D.				23B. DATE SIGNED 4/21/67	
23C. PHYSICIAN'S NAME (Type) Clayton Moravic				23D. ADDRESS 4940 Eastern Avenue Baltimore, Md. #21224	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-26-67		24C. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Pk.	
24D. LOCATION Arbutus Maryland		25A. DATE REC'D BY HEALTH DEPT.			
25B. NAME OF REGISTRAR 022-52-7-6-8		25C. FUNERAL DIRECTOR Kelson Funeral Home 1348 Calhoun St.			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT																			
BIRTH NO. 67 4037					CERTIFICATE OF DEATH					Registered No. 67 4037									
1. NAME OF DECEASED (Type or Print) George Myrick					2. DATE AND HOUR OF DEATH 4-20-67					M.									
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 44 Union Memorial Hosp.					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto. D. STREET ADDRESS (If rural, give location) 1717 E. 29th St.														
5. SEX M		6. RACE Negroid		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married		8. DATE OF BIRTH 3-29-00		9. AGE (In years last birthday) 67		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.							
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10B. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country) N.C.									
12. CITIZEN OF WHAT COUNTRY? U.S.A.					13. FATHER'S NAME Henry Myrick					14. MOTHER'S MAIDEN NAME May									
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.					17. INFORMANT ADDRESS Mrs. Leo Chase 2741 E. Chase St.									
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										CAUSE OF DEATH (A) Myocardial Infarction DUE TO (B) Generalized Coronary Atherosclerosis DUE TO (C) Arteriosclerosis Hypertensive Cardiovascular disease					INTERVAL BETWEEN ONSET AND DEATH				
MEDICAL CERTIFICATION																			
19A. DATE OF OPERATION 0-					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No)									
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)									
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?									
22. I certify that (I) (this hospital) attended the deceased from Jan 19 66 to March 30 19 67 , that (I) (we) last saw the deceased alive on 3/30 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.																			
23A. SIGNATURE Stanley D. Madison, M.D.										23B. DATE SIGNED 4/21/67									
23C. PHYSICIAN'S NAME (Type) Stanley D. Madison, M.D.										23D. ADDRESS 2444 E. Biddle St. Baltimore, Md 21213									
24A. BURIAL CREMATION, REMOVAL (Specify) Burial					24B. DATE 4-27-67					24C. NAME OF CEMETERY OR CREMATORY Church Cemetery									
24D. LOCATION Infield, North Carolina					24E. FUNERAL DIRECTOR Nelson Funeral Home					24F. ADDRESS 1348 Calhoun St.									
25A. DATE REC'D BY HEALTH DEPT. APR 25 1967 25B. NAME OF REGISTRAR John H. Johnson																			

1
S-152

67 4038

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 4038

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

STARLING SPENCER

2. DATE AND HOUR PRONOUNCED DEAD

April 22, 1967 11:50 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

38/99 University Hospital (DOA)

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2740 Beryl Avenue

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

6/1/26

9. AGE (In years last birthday)

44

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Seaman

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF WHAT COUNTRY?

U S A

13. FATHER'S NAME

Ernest Spencer

14. MOTHER'S MAIDEN NAME

Connie

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Mrs Emma Spencer 2740 Beryl Ave

18. E 812.4

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Fracture of cervical spine
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2/1

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

highway

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Baltimore - Expressway near Route 695 / Washington

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

4-22-67 11:21 P.

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Pedestrian struck by car

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

April 23, 1967

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

4/27/67

23C. NAME OF CEMETERY or CREMATORY

Mt Calvary Cemetery

23D. LOCATION

A A County Md

24A. DATE REC'D BY HEALTH DEPT.

APR 25 1967

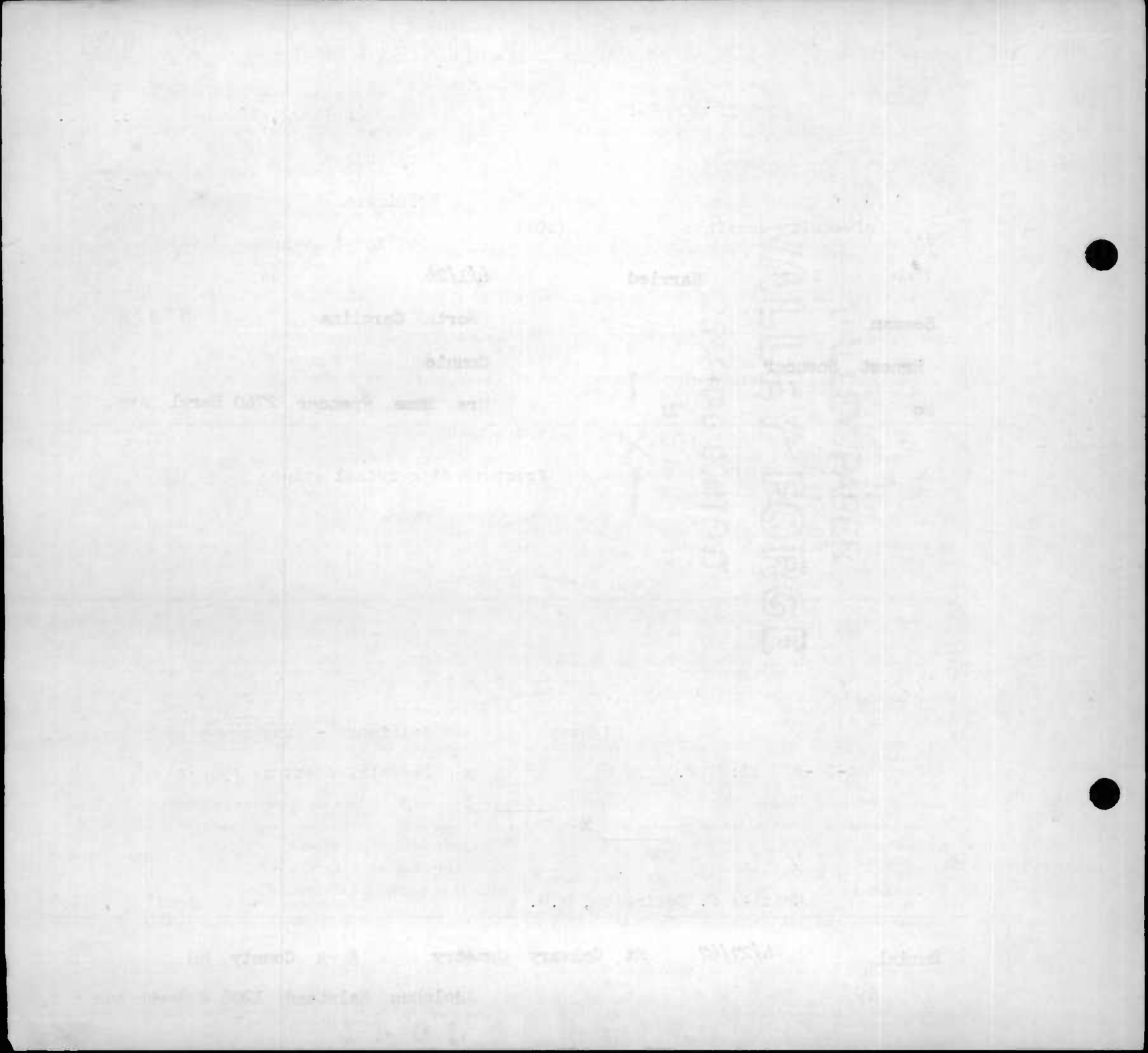
24B. NAME OF REGISTRAR

Dr. E. J. Taylor

24C. FUNERAL DIRECTOR

Adolphus Halstead 1206 W North Ave

ADDRESS



67 4039
BIRTH NO. 46-27823 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 4039

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) GREGORY WILSON

2. DATE AND HOUR PRONOUNCED DEAD April 19, 1967 8:55 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
CERTIFICATE AMENDED
(If not in hospital or institution, give street address or location) 5-5-67
2414 Maisel Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2414 Maisel Street

5. SEX Male 6. RACE Negro 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Child

8. DATE OF BIRTH December 22, 1966 9. AGE (In years last birthday) 4 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child 10B. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Gregory Dixon 14. MOTHER'S MAIDEN NAME Joann Wilson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT ADDRESS

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
CAUSE OF DEATH
Bronchopneumonia
INTERSTITIAL PNEUMONITIS (SDII)
DUE TO
(A) DUE TO
(B) DUE TO
(C) DUE TO
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) Yes 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ 21F. HOW DID INJURY OCCUR?

22. I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐
CHIEF MEDICAL EXAMINER ☐
ACTUAL SIGNATURE Charles S. Petty M.D. ASSISTANT MEDICAL EXAMINER ☒ DATE SIGNED 4/20/67
EXAMINER'S NAME (Type) Charles S. Petty ASSOCIATE MEDICAL EXAMINER ☐

23A. BURIAL CREMATION, REMOVAL (Specify) Burial 23B. DATE 4/24/67 23C. NAME OF CEMETERY or CREMATORY Mt Auburn Cemetery 23D. LOCATION (City, town, or county) (State) Baltimore Md

24A. DATE REC'D BY HEALTH DEPT. APR 25 1967 24B. NAME OF REGISTRAR Robert E. Johnson 24C. FUNERAL DIRECTOR Adolphus Halstead 1206 W North Ave ADDRESS

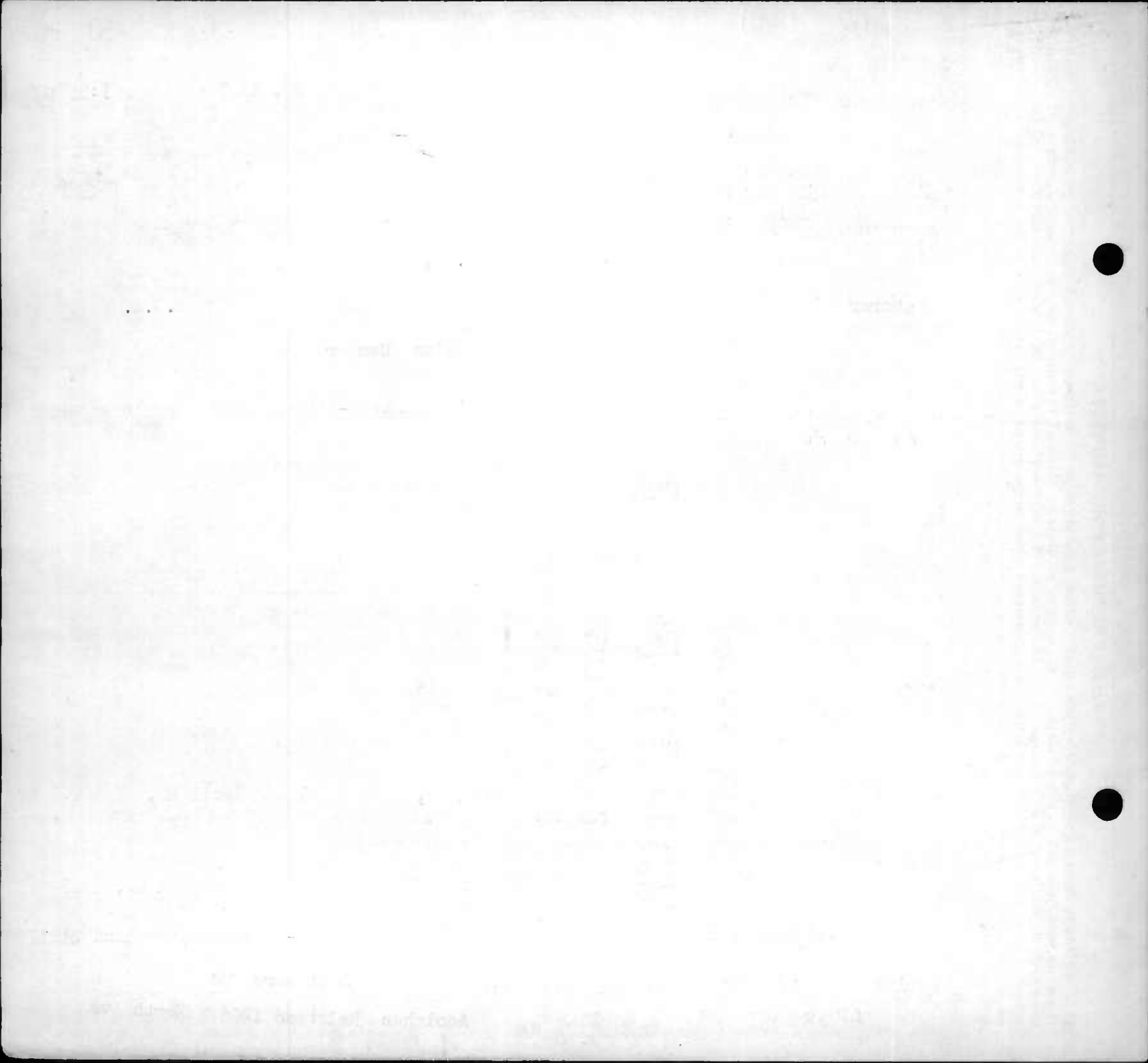
Letter from M.E.'s office

5-5-67 M.H.

FUNERAL DIRECTOR: IMPORTANT

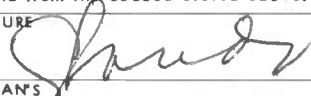
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

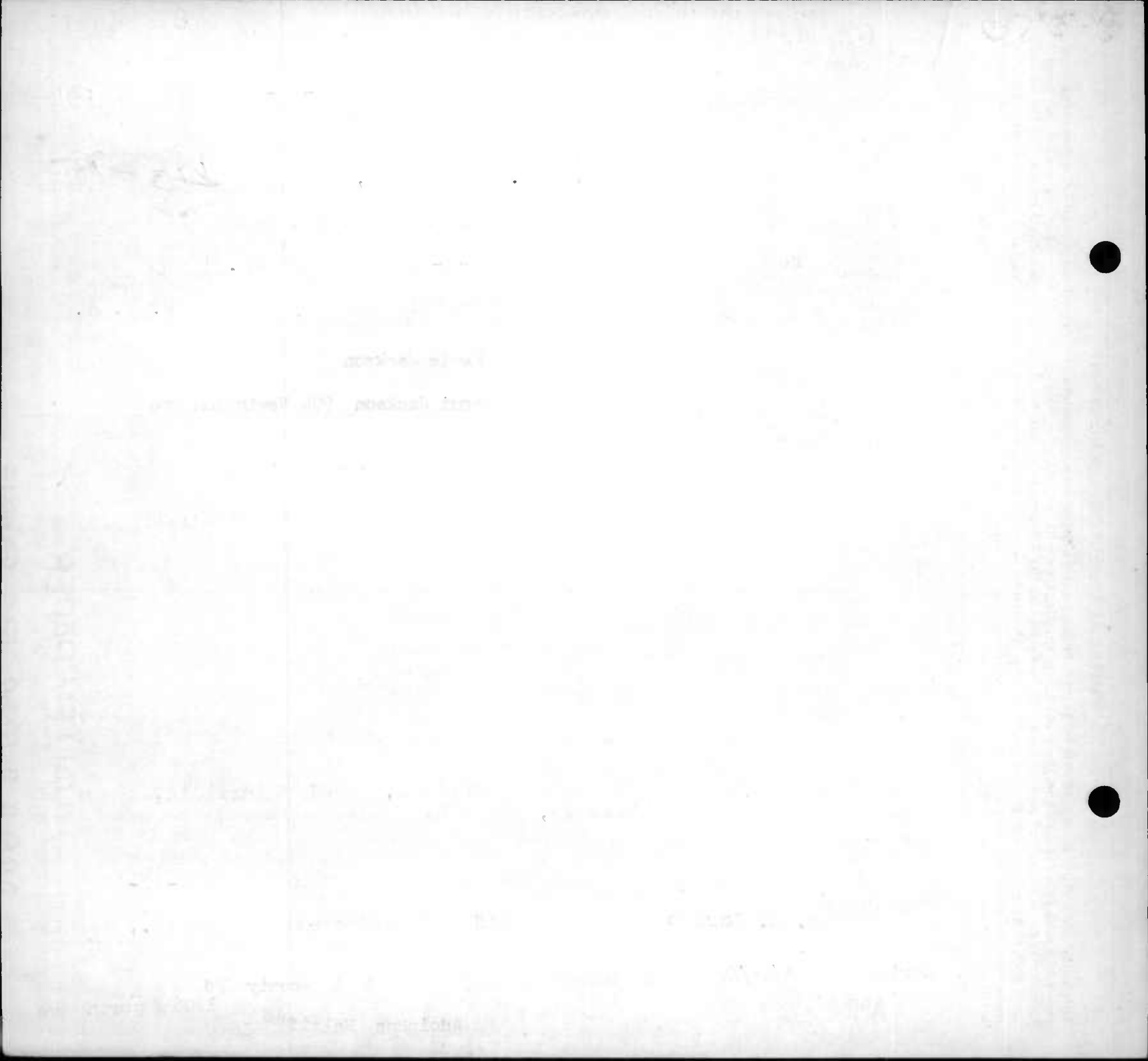
BIRTH NO. 67 4040		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 67 4040	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) George Black			2. DATE AND HOUR OF DEATH April 20, 1967 8:55 p.m.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION Provident Hospital 1514 Division Street Baltimore, Maryland 21217			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 14-02 D. STREET ADDRESS (If rural, give location) 1428 Argyle Avenue		
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH Aug. 5, 1916	9. AGE (In years last birthday) 50	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) North Carolina	
13. FATHER'S NAME			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) ?			16. SOCIAL SECURITY NO.		17. INFORMANT Mamie Chambers-sister
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Pneumonia			CAUSE OF DEATH (A) DUE TO Pneumonia of Esophagus with Metastasis (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH
MEDICAL CERTIFICATION					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Pneumonia					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from April 14, 1967 to April 20, 1967 , that (I) (we) lost saw the deceased alive on April 20, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Rosario Bello			M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED April 21, 1967
23C. PHYSICIAN'S NAME (Type) Rosario Bello			M.D. 23D. ADDRESS 1514 Division Street-Baltimore, Maryland 21217		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/24/67		24C. NAME OF CEMETERY or CREMATORY Arbutus Mem Park	
24D. LOCATION Baltimore Md		25A. DATE REC'D BY HEALTH DEPT. APR 25 1967			
25B. NAME OF REGISTRAR Adolphus Halstead		25C. FUNERAL DIRECTOR Adolphus Halstead		ADDRESS 1206 W North Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 4041</u>	
BIRTH NO. <u>67 4041</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) <u>James Jackson</u>		2. DATE AND HOUR OF DEATH <u>4-18-67</u> <u>1:30 AM.</u>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Provident Hospital, Inc.</u> <u>39</u>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>11-04</u> D. STREET ADDRESS (If rural, give location) <u>213 Lafayette Avenue</u>			
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Single</u>	8. DATE OF BIRTH <u>2-4-28</u>	9. AGE (In years last birthday) <u>48 yrs.</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Georgia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>?</u>		14. MOTHER'S MAIDEN NAME <u>Mamie Jackson</u> <u>?</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>Naomi Jackson 904 Newington Ave</u>	
18. <u>445X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Malignant Hypertension</u> (A) DUE TO <u>Hypertensive encephalopathy</u> (B) DUE TO (C) _____		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>April 2, 1967</u> to <u>April 18, 1967</u> , that (I) (we) lost saw the deceased alive on <u>April 18, 1967</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>4-18-67</u>	
23C. PHYSICIAN'S NAME (Type) <u>Dr. C. Laredo</u>		23D. ADDRESS M.D. <u>1514 Division Street Balto., Maryland</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/25/67</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mt Calvary Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>A A County Md</u>					
25A. DATE RECEIVED BY HEALTH DEPT. <u>APR 25 1967</u>		25B. NAME OF REGISTRAR <u>Adolphus Halstead</u>		25C. FUNERAL DIRECTOR ADDRESS <u>1206 W North Ave</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
CERTIFICATE OF DEATH					Registered No. <u>67 4042</u>					
BIRTH NO. <u>67 4042</u>		M.E. CASE NO.			2. DATE AND HOUR OF DEATH <u>APR. 23, 1967</u> <u>7²⁰</u> <u>A.M.</u>					
1. NAME OF DECEASED (Type or Print) <u>PETERSON, EDWARD WISE</u>										
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>UNIVERSITY OF MARYLAND</u> <u>38 HOSPITAL</u>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>X</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> D. STREET ADDRESS (If rural, give location) <u>901 CHERRY HILL #25 Rd</u>					
5. SEX <u>M</u>	6. RACE <u>NEGRO</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH <u>4-15-1890</u>	9. AGE (In years last birthday) <u>77</u>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Long shoreman</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Arthur Peterson</u>					14. MOTHER'S MAIDEN NAME <u>Rose Ellen</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO. <u>218-07-7683</u>		17. INFORMANT <u>Chart</u>				ADDRESS	
18. <u>420.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) <u>ASCD & progressive congestive heart failure</u> (B) <u>possible recent myocardial infarction</u> (C)			INTERVAL BETWEEN ONSET AND DEATH <u>13 days</u> <u>10-13 days</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Gangrene Lt foot due to ASCD</u>										
19A. DATE OF OPERATION <u>0</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <u>4/23 19 67</u> to <u>4/23 19 67</u> and that (I) (we) last saw the deceased alive on <u>4/23 19 67</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE <u>Elisah Saunders</u>					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED <u>4/23/67</u>		
23C. PHYSICIAN'S NAME (Type) <u>ELISAH SAUNDERS</u>					23D. ADDRESS <u>3414 Duwall ave. Baltimore</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/28/67</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mt Calvary Cemetery</u>			24D. LOCATION (City, town, or county) (State) <u>A A County Md</u>			
25A. DATE REC'D BY HEALTH DEPT.			25B. NAME OF REGISTRAR <u>Adolphus Halstead</u>			25C. FUNERAL DIRECTOR <u>1206 W North Ave</u>				

APR 25 1967

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PETERSON, EDWARD

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UNIVERSITY OF MICHIGAN

HOSPITAL

251 CHERRY HILL # 32

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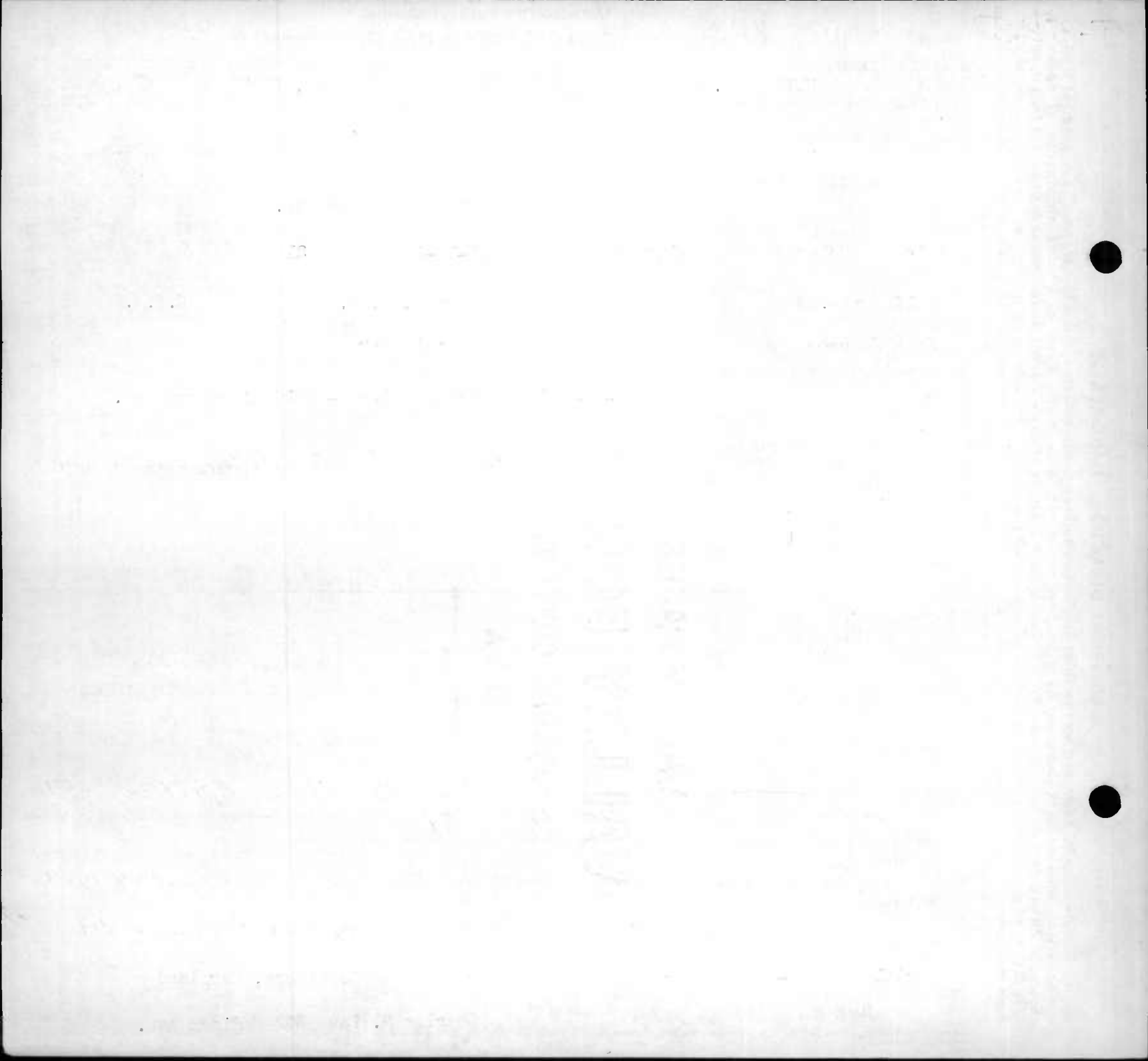
27

OFFICE OF THE
CLERK OF THE
COURT

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 4043	
BIRTH NO. 67 4043		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) UDYSSES S. JOHNSON		2. DATE AND HOUR OF DEATH APRIL 20, 1967 8:55 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 3520 Hilton Road		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 3929 Ridgewood Ave.			
5. SEX Male	6. RACE Colored	7. MARRIED, NEVER MARRIED WIDOWED DIVORCED (specify) Widower	8. DATE OF BIRTH 11-16-1885	9. AGE (In years last birthday) 81	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self Employed		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Laurens, S. C.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John Johnson			14. MOTHER'S MAIDEN NAME Rose Hunter		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-03-5962		17. INFORMANT ADDRESS Gladys Lyles - 3929 Ridgewood Ave.	
18. CAUSE OF DEATH <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>177X I</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>Antecedent Causes</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> </div> <div style="width: 45%;"> <p>(A) DUE TO Cancer of prostate with metastases</p> <p>(B) DUE TO</p> <p>(C)</p> </div> <div style="width: 10%;"> <p>INTERVAL BETWEEN ONSET AND DEATH unknown</p> </div> </div>					
<p style="text-align: center;">II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p>					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from April 19, 1967 to April 20, 1967 , that (I) (we) last saw the deceased alive on April 19, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (and) (did not) view the body after death.					
23A. SIGNATURE Abraham B. Hurwitz M.D.				23B. DATE SIGNED April 24, 1967	
23C. PHYSICIAN'S NAME (Type) ABRAHAM B. HURWITZ				23D. ADDRESS 7501 Liberty Road Baltimore, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-24-67		24C. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Park	
				24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. APR 25 1967		25B. NAME OF REGISTRAR Charles E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Charles R. Law 802 Madison Ave.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
67 4044				67 4044	
BIRTH NO.				M.E. CASE NO.	
1. NAME OF DECEASED (Type or Print) <i>Robert A. Miller</i>			2. DATE AND HOUR OF DEATH <i>4/23/67</i> <i>11:50 P.</i> M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MD.</i> B. COUNTY <i>Baltimore</i>		
FULL NAME OF HOSPITAL OR INSTITUTION <i>43 S. Balto. General Hosp.</i>			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> <i>21-02</i>		
D. STREET ADDRESS (If rural, give location) <i>1235 Cleveland St.</i>			5. SEX <i>Male</i> 6. RACE <i>White</i> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Married</i>		
8. DATE OF BIRTH <i>5/4/1907</i>			9. AGE (In years lost birthday) <i>59</i>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Chauffeur</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>Eastman Kodak</i>		
11. BIRTHPLACE (State or foreign country) <i>MD.</i>			12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Herbert Miller</i>			14. MOTHER'S MAIDEN NAME <i>Alice Quinn</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO. <i>2 15-05-1363</i>		
17. INFORMANT <i>Mrs. Rose J. Miller</i>			ADDRESS <i>Above</i>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <i>260 XI</i>			CAUSE OF DEATH (A) DUE TO <i>Coronary Thrombosis</i>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO <i>Hypertensive Cardiovascular Disease</i> <i>3 yr</i>		
			(C) <i>Diabetes Mellitus</i> <i>3 yr</i>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>2/10</i> 19 <i>63</i> to <i>4/23</i> 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>4/23</i> 19 <i>67</i> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Joseph G. Laukaitis MD</i>				23B. DATE SIGNED <i>4/24/67</i>	
23C. PHYSICIAN'S NAME (Type) <i>JOSEPH G. LAUKAITIS MD</i>				23D. ADDRESS <i>679 Washington Blvd Baltimore MD</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>4/27/67</i>		24C. NAME OF CEMETERY OR CREMATORY <i>New-Cathedral Cem.</i>	
24D. LOCATION (City, town, or county) (State) <i>4300 Old Frederick Rd. Baltimore MD</i>		25A. DATE REC'D BY HEALTH DEPT. <i>APR 25 1967</i>		25B. NAME OF REGISTRAR <i>John J. Gowanlock Inc.</i>	
25C. FUNERAL DIRECTOR <i>John J. Gowanlock Inc.</i>		25D. ADDRESS <i>23, 7nd.</i>			

THE END OF THE WORLD

WINTER & FALL

1. 1st. 2nd. 3rd. 4th. 5th. 6th. 7th. 8th. 9th. 10th. 11th. 12th.

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12.

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12.

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12.

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12.

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12.

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12.

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12.

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12.

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12.

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12.

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12.

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12.

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12.

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | Registered No. 67 4045 | |
|---|------------------|---|---|--|--|--|--|--|---------|--|--|
| BIRTH NO. 67 4045 | | | | | | | | | | 67 4045 | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) SARAH BARIS | | | | | 2. DATE AND HOUR OF DEATH
4/22/67 1 130 P M. | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

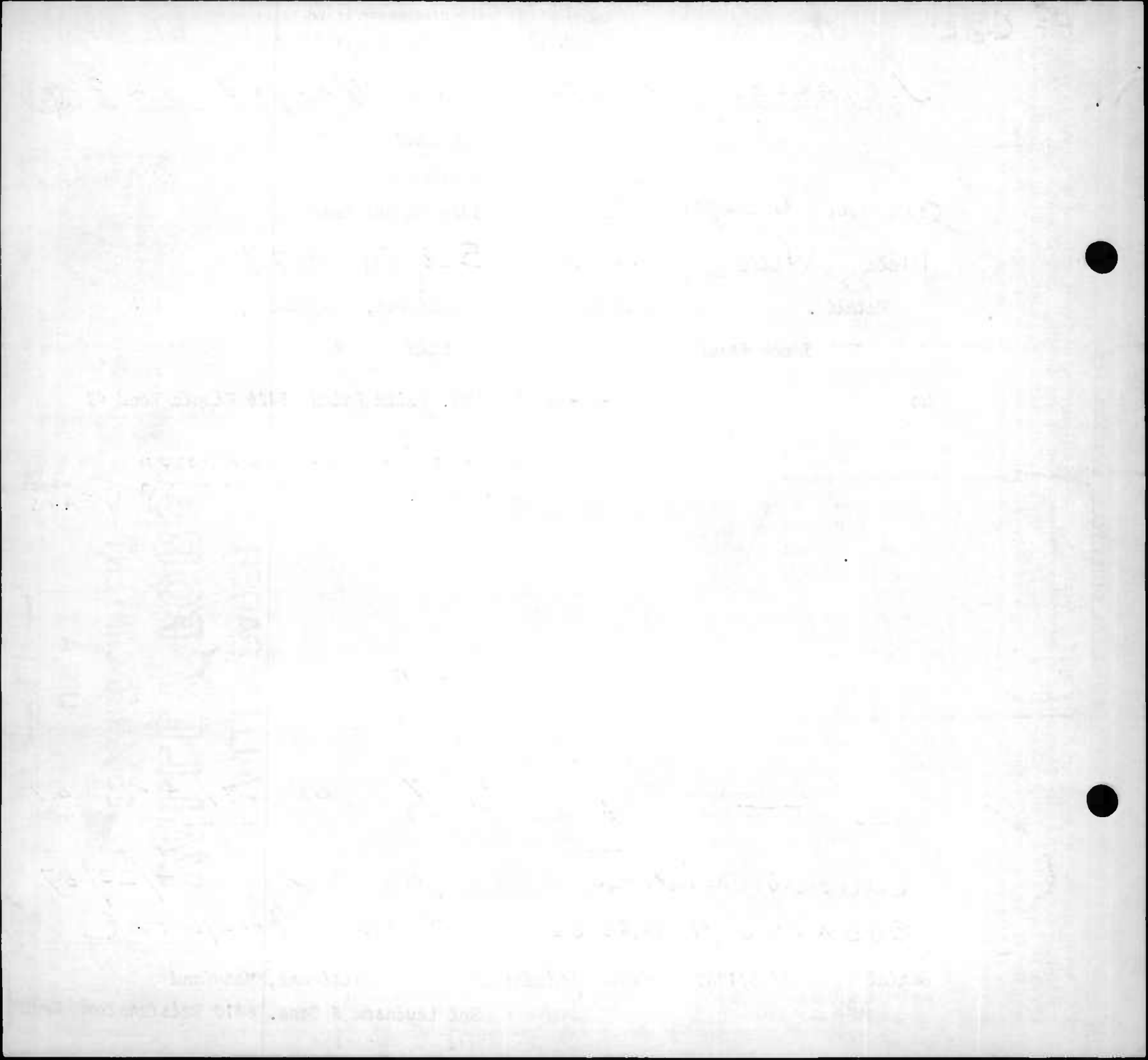
FULL NAME OF HOSPITAL OR INSTITUTION 42 Sinai Hospital
(If not in hospital or institution, give street address or location) | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD.
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 28-02
D. STREET ADDRESS (If rural, give location) 5510 Gwynn Oak Ave. | | | | | | |
| 5. SEX
Female | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
WIDOW | | 8. DATE OF BIRTH
10/8/90 | 9. AGE (In years
last birthday) 76 | If Under 1 Yr.
Months Days | | If Under 24 Hrs.
Hours Min. | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | | 10B. KIND OF BUSINESS OR INDUSTRY
At Home | | 11. BIRTHPLACE (State or foreign country)
***** Poland | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | |
| 13. FATHER'S NAME
? CORN BLATT | | | | | 14. MOTHER'S MAIDEN NAME
Anna ? | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)
No | | | 16. SOCIAL SECURITY NO.
No | | 17. INFORMANT ADDRESS Ave.
CHART Mrs. Rose B. Levin 3503 Milford | | | | | | |
| 18. 420.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | CAUSE OF DEATH
(A) MYOCARDIAL INFARCTION
DUE TO
(B) DUE TO
(C) DUE TO | | | | | INTERVAL BETWEEN ONSET AND DEATH
40A. | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No)
NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 4/18 19 67 to 4/22 19 67, that (I) (we) last saw the deceased alive on 4/22 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE
SHELDON FRANK M.D. | | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input type="checkbox"/> | | | 23B. DATE SIGNED
4/22/67 | | | |
| 23C. PHYSICIAN'S NAME (Type)
SHELDON FRANK M.D. | | | | | 23D. ADDRESS
Sinai Hospital | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
4/23/1967 | | 24C. NAME of CEMETERY or CREMATORY
Workmen Circle | | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 25 1967 | | | 25B. NAME OF REGISTRAR
R. G. E. Johnson | | | 25C. FUNERAL DIRECTOR
Sol Levinson & Bros. 6010 Reisterstown Road | | | ADDRESS | | |

[Faint, illegible text and markings, possibly bleed-through from the reverse side of the page. Some faint words like "The" and "and" are visible.]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 67 4046 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | REGISTERED No. 67 4046 | |
|---|-------------------------|--|------------------------------------|---|--|---|-----------------------|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) J. CHARLES FRIED | | | | 2. DATE AND HOUR OF DEATH
4/22/67 2.25 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Sinai Hospital | | | | A. STATE Maryland | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | | | |
| | | | | D. STREET ADDRESS (If rural, give location)
3426 Ripple Road | | | |
| 5. SEX
Male | 6. RACE
White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
married | 8. DATE OF BIRTH
5/28/89 | 9. AGE (In years last birthday)
77 | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retail. | | 10B. KIND OF BUSINESS OR INDUSTRY
Salesman | | 11. BIRTHPLACE (State or foreign country)
Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Jacob Fried | | | | 14. MOTHER'S MAIDEN NAME
Etta ? | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
219-03-4322A | | 17. INFORMANT ADDRESS
Mrs. Yetta Fried 3426 Ripple Road #7 | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
293XI | | | | CAUSE OF DEATH
(A) DUE TO
Anemia of unknown origin | | INTERVAL BETWEEN ONSET AND DEATH
8 YEARS | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) DUE TO | | | |
| | | | | (C) DUE TO | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
no | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 4/17 1967 to 4/22 1967 , that (I) (we) last saw the deceased alive on 4/22 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
Eduardo Hidalgo M.D. | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
4/22/67 | |
| 23C. PHYSICIAN'S NAME (Type)
EDUARDO HIDALGO M.D. | | | | 23D. ADDRESS
Sinai Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
4/23/1967 | | 24C. NAME OF CEMETERY OR CREMATORY
Hebrew Friednsip | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | |
| 25A. DATE REC'D. BY HEALTH DEPT.
APR 25 1967 | | 25B. NAME OF REGISTRAR
Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR
Sol Levinson & Bros. | | ADDRESS
6010 Reisterstown Road | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 4047 | |
|--|---|--|---|--|--|
| BIRTH NO. 67 4047 | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED
(Type or Print) Leah Graneb | | | 2. DATE AND HOUR OF DEATH
April 21, 1967 12²⁵ PM. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE MARYLAND
B. COUNTY BALTIMORE | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
Levinale, Hebrew Home and Infirmary | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | | |
| D. STREET ADDRESS (If rural, give location)
2805 OAKLEY AVENUE | | | E. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE | | |
| 5. SEX
Female | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
widowed | 8. DATE OF BIRTH
MAY 1911 | 9. AGE (In years last birthday)
55 | 10. Under 1 Yr. Months: Days: Hours: Min.
If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWIFE | | | 11. BIRTHPLACE (State or foreign country)
LATVIA | | |
| 10B. KIND OF BUSINESS OR INDUSTRY
AT HOME | | | 12. CITIZEN OF WHAT COUNTRY?
USA | | |
| 13. FATHER'S NAME
MORRIS OREM | | | 14. MOTHER'S MAIDEN NAME
BLUMA ? | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | | 16. SOCIAL SECURITY NO.
NO | | |
| 17. INFORMANT
MR. MORRIS GRANEK, 6800 LIBERTY ROAD, APT 711 | | | ADDRESS | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
recurrent pulmonary emboli 4 days | | | CAUSE OF DEATH
Phlebothrombosis | | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
A SCVD + cong. heart failure | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| 20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 21A. DATE OF OPERATION
NO | | 21B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 21C. AUTOPSY? (Yes or No)
no | |
| 21D. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21E. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21F. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21G. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21H. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21I. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Nov. 3, 1964 to April 21, 1967 , that (I) (we) last saw the deceased alive on April 21, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Ruth Willner | | | 23B. DATE SIGNED
April 21, 1967 | | |
| 23C. PHYSICIAN'S NAME (Type)
Ruth Willner | | | 23D. ADDRESS
Levinale, Hebrew Home and Infirmary | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
4/23/67 | | 24C. NAME OF CEMETERY or CREMATORY
CHIZUK AMINO (ARLINGTON) | |
| 24D. LOCATION (City, town, or county) (State)
BALTIMORE, MARYLAND | | 24E. NAME OF REGISTRAR
Robert E. Taylor | | 24F. FUNERAL DIRECTOR
SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN | |
| 25A. DATE RECEIVED BY HEALTH DEPT.
APR 25 1967 | | 25B. NAME OF REGISTRAR
Robert E. Taylor | | | |

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

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100-100000

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>67 4048</u> | |
|--|-------------------------|--|-------------------------------------|---|---|
| BIRTH NO. <u>67 4048</u> | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) <u>HESS, ROBERT</u> | | | |
| 2. DATE AND HOUR OF DEATH
<u>22 APRIL 67</u> <u>6 50</u> M. | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<u>UNION MEMORIAL HOSP.</u> | | | |
| 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <u>MD</u> B. COUNTY <u>BALTIMORE</u> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>BALTIMORE</u> | | | |
| D. STREET ADDRESS (If rural, give location)
<u>119 W. 2 AFAYETTE AVE</u> | | E. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>11-02</u> | | | |
| 5. SEX
<u>Male</u> | 6. RACE
<u>White</u> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<u>MARRIED</u> | 8. DATE OF BIRTH
<u>11-28-27</u> | 9. AGE (In years last birthday)
<u>39</u> | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>LAWYER</u> |
| 11. BIRTHPLACE (State or foreign country)
<u>MD., Baltimore</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | 13. FATHER'S NAME
<u>Emanuel HESS</u> | |
| 14. MOTHER'S MAIDEN NAME
<u>ALICE ROSENSTOCK</u> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>no</u> | | 16. SOCIAL SECURITY NO.
<u>213-28-3241</u> | |
| 17. INFORMANT
<u>Mrs. Jane Hess</u> | | 18. ADDRESS
<u>119 W. Lafayette AVE.</u> | | 19. CAUSE OF DEATH
<u>Massive pulmonary embolization</u> | |
| 20. DUE TO
<u>Femoral phlebotomy</u> | | 21. DUE TO
<u>EM</u> | | 22. INTERVAL BETWEEN ONSET AND DEATH
<u>2</u> | |
| 23. DUE TO
<u>Hemiplegia - left</u> | | 24. DUE TO
<u>EM</u> | | 25. INTERVAL BETWEEN ONSET AND DEATH
<u>2</u> | |
| 26. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
<u>II</u> | | 27. DATE OF OPERATION
<u>2</u> | | 28. CONDITION FOR WHICH OPERATION WAS PERFORMED
<u>yes</u> | |
| 29. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 30. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
<u>yes</u> | | 31. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
<u>yes</u> | |
| 32. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)
<u>22 APRIL 1967</u> | | 33. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 34. HOW DID INJURY OCCUR?
<u>yes</u> | |
| 22. I certify that <u>4</u> (this hospital) attended the deceased from <u>5 APRIL 1967</u> to <u>22 APRIL 1967</u> , that <u>4</u> (we) last saw the deceased alive on <u>22 APRIL 1967</u> and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. (I) <u>we</u> (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>Sidney E. Kirkley</u> | | 23B. DATE SIGNED
<u>22 April 67</u> | | 23C. PHYSICIAN'S NAME (Type)
<u>DR SIDNEY E. KIRKLEY</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>4/23/1967</u> | | 24C. NAME OF CEMETERY or CREMATORY
<u>Baltimore, Hebrew</u> | |
| 24D. LOCATION (City, town, or county) (State)
<u>Baltimore, Maryland</u> | | 25A. DATE REC'D BY HEALTH DEPT.
<u>APR 25 1967</u> | | 25B. NAME OF REGISTRAR
<u>Sol Levinson & Bros.</u> | |
| 25C. FUNERAL DIRECTOR
<u>Sol Levinson & Bros.</u> | | 25D. ADDRESS
<u>6010 Reisterstown Road</u> | | 25E. ADDRESS
<u>6010 Reisterstown Road</u> | |

HE 22, 1942

1/19 M. LARABETTE

United Nations

M. W. HARRIS

11-24-42

1942

M. W. HARRIS

223

ALICE ROSENBERG

General Hospital
New York City

1942

1942

1942

1942

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | Registered No. 67 4049 | |
|--|--|---|--|--|--|--|--|---|--|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| BIRTH NO.
67 4049 | | M.E. CASE NO.
S. | | 1. NAME OF DECEASED
(Type or Print)
Howard Pollack | | | | 2. DATE AND HOUR OF DEATH
APRIL 21 1967 3 42 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
SINAI HOSPITAL OF BALTIMORE | | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD
B. COUNTY —
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE
D. STREET ADDRESS (If rural, give location)
3104 Labyrinth Rd. | | | | | |
| 5. SEX
MALE | | 6. RACE
CAUC. | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
MARRIED | | 8. DATE OF BIRTH
4-25-28 | | 9. AGE (In years last birthday)
38 | | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
ATTORNEY | | | | 10B. KIND OF BUSINESS OR INDUSTRY
AT LAW | | 11. BIRTHPLACE (State or foreign country)
BROOKLYN, NEW YORK | | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A | |
| 13. FATHER'S NAME
DR. ABRAHAM POLLACK | | | | | | 14. MOTHER'S MAIDEN NAME
RAE COOPER | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | | | 16. SOCIAL SECURITY NO.
UNKNOWN | | 17. INFORMANT
MRS. MARSHA POLLACK, 3104 LABYRINTH ROAD #8 | | | | ADDRESS | |
| 18. 420.11
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

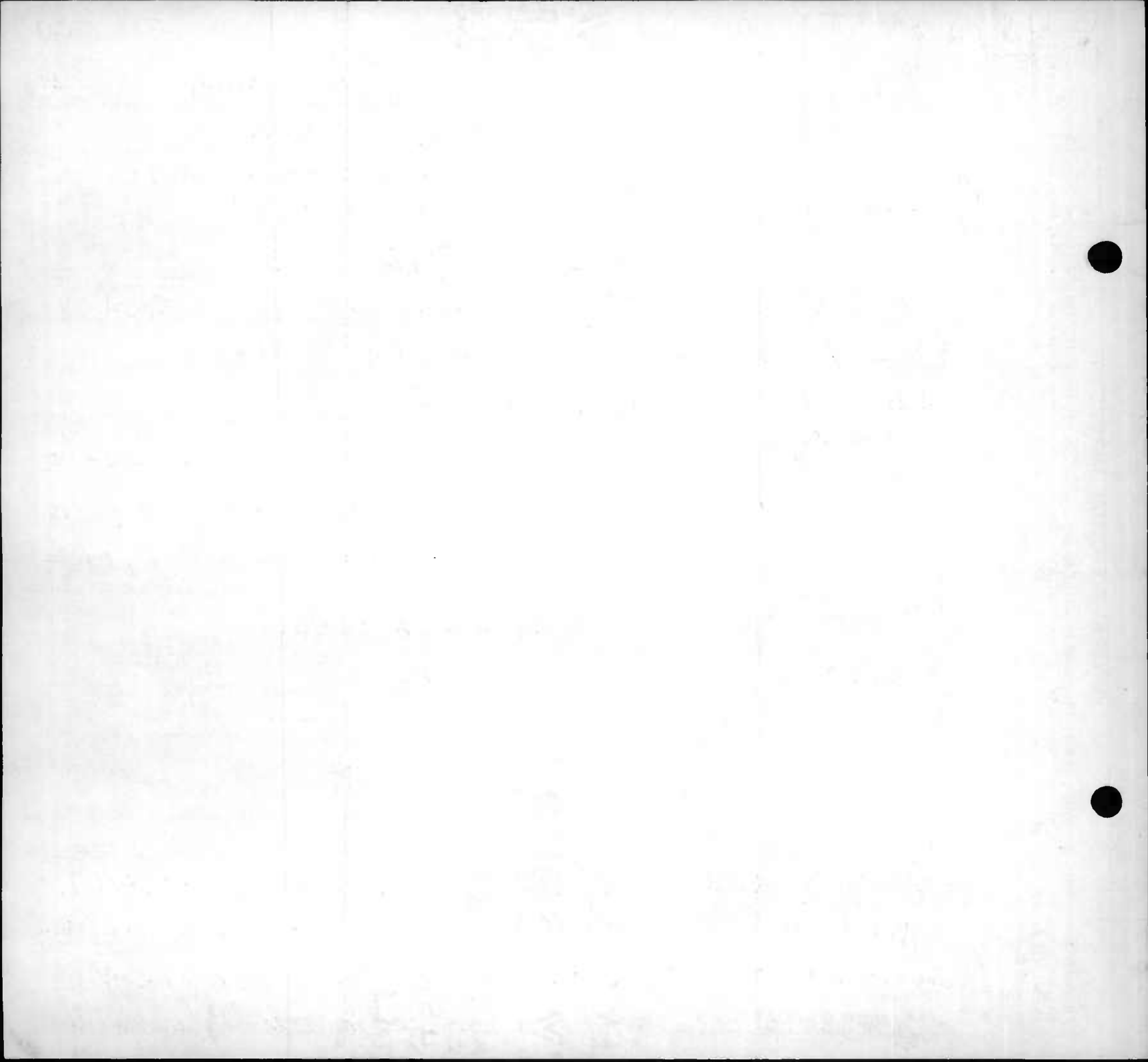
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | CAUSE OF DEATH
(A) MYOCARDIAL INFARCTION
DUE TO
(B)
DUE TO
(C)
INTERVAL BETWEEN ONSET AND DEATH
2 HOURS | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> UNDERLYING <input type="checkbox"/> CAUSE OF DEATH | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) <u>this hospital</u> attended the deceased from <u>APRIL 21 1967</u> to <u>APRIL 21 1967</u> , that (I) <u>we</u> lost saw the deceased alive on <u>APRIL 21 1967</u> and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. (I) <u>We</u> <u>(did)</u> (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE
Melvin B. Lewis | | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED
APRIL 21, 1967 | |
| 23C. PHYSICIAN'S NAME (Type)
MELVYN B. LEWIS | | | | | | 23D. ADDRESS
M.D. SINAI HOSPITAL OF BALTIMORE | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
4/23/67 | | 24C. NAME OF CEMETERY OR CREMATORY
BALTIMORE HEBREW | | | | 24D. LOCATION (City, town, or county) (State)
REISTERSTOWN, MARYLAND | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 25 1967 | | | | 25B. NAME OF REGISTRAR
Robert E. Taylor | | | | 25C. FUNERAL DIRECTOR ADDRESS
SOL LEVINSON & BROS. INC., 6010 REIST., RD. | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|-------------|---|-------------------------|---|--|
| BIRTH NO. 67 4050 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 4050 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | 2. DATE AND HOUR OF DEATH 4/22/67 1:20 PM A.M. | |
| 1. NAME OF DECEASED (Type or Print) KATHRYN C PHELAN | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY HOSPITAL BALTIMORE MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE N.Y. B. COUNTY N.Y. C. CITY OR TOWN (If outside city limits, write RURAL and give township) JACKSON HGTS. N.Y. D. STREET ADDRESS (If rural, give location) 3447 90TH ST. | | | |
| 5. SEX F | 6. RACE Can | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED | 8. DATE OF BIRTH 4/7/12 | 9. AGE (In years last birthday) 55 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WIDOW |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WIDOW | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MARYLAND | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME EARL V. CARTER | | 14. MOTHER'S MAIDEN NAME HELEN DUFFEY | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | |
| 16. SOCIAL SECURITY NO. 083-01-0938 | | 17. INFORMANT CHART. ADDRESS | | | |
| 18. 163 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES | | (A) DUE TO RESPIRATORY INSUFFICIENCY | | 24 HOURS | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO CARCINOMA OF LUNG | | 2 YEARS | |
| | | (C) MULTIPLE METASTASES | | 1 YEAR | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | BRONCHIAL ASTHMA. | | | |
| 19A. DATE OF OPERATION 0 NONE | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Chris J Beutel | | | | 23B. DATE SIGNED 4/22/67 | |
| 23C. PHYSICIAN'S NAME (Type) CHRISTOPHER J. BEETEL | | | | 23D. ADDRESS UNIVERSITY HOSP BALTIMO. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Cremation | | 24B. DATE 4/25/67 | | 24C. NAME OF CEMETERY OR CREMATORY Fresh Pond Crematory | |
| 24D. LOCATION (City, town, or county) Queens, New York | | 24E. STATE N.Y. | | 24F. ADDRESS | |
| 25A. DATE REC'D BY HEALTH DEPT. APR 25 1967 | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |



1
M-460

| | | | | | |
|---|-------------------------|--|---|---|---|
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print)
AUBREY Carlton MILLER | | 2. DATE AND HOUR PRONOUNCED DEAD
April 22, 1967 12:01 AM. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION
Baltimore City Hospital (DOA) | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Ohio
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Columbus
D. STREET ADDRESS (If rural, give location) 1618 E. Main St. | | | |
| 5. SEX
Male | 6. RACE
White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
Married | 8. DATE OF BIRTH
April 9-1897 | 9. AGE (In years last birthday)
70 | If Under 1 Yr. If Under 24 Mos. Days Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired, | | 10B. KIND OF BUSINESS OR INDUSTRY
Coal Miner | | 11. BIRTHPLACE (State or foreign country)
West Virginia | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
James A. Miller | | 14. MOTHER'S MAIDEN NAME
Rosie Wills | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service)
Yes, Army WWI | | 16. SOCIAL SECURITY NO.
233-16-6693 | | 17. INFORMANT ADDRESS
4, a, b, c, d. & Wife, Mrs. Mary Miller, 8013 Charlesmont Rd. | |
| 18. CAUSE OF DEATH
422.1
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Arteriosclerotic cardiovascular disease
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
ANTECEDENT CAUSES
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | CAUSE OF DEATH
Dundalk, Md. 21222 | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>
ACTUAL SIGNATURE Charles S. Springate M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>
EXAMINER'S NAME (Type) Charles S. Springate, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 4-22-67 | | | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 23B. DATE
April 26-1967 | | 23C. NAME OF CEMETERY or CREMATORY
Baltimore National | |
| 24A. DATE REC'D BY HEALTH DEPT. | | 24B. NAME OF REGISTRAR
John J. Duda | | 24C. FUNERAL DIRECTOR ADDRESS
Baltimore, Maryland 21222 | |

APR 25 1967 9870004052

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | 67 4052 | |
|---|---------------------|--|--|---|--|---|--|--|---|----------------|--|
| CERTIFICATE OF DEATH | | | | | | | | | | Registered No. | |
| BIRTH NO. 67 4052 | | | | | | | | | | | |
| M.E. CASE NO. | | | | | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) PIKE, MR WALTER | | | | | | 2. DATE AND HOUR OF DEATH
4. 22. 67 9. 15 P.M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD. B. COUNTY Baltimore Co. | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
35 CHURCH HOME & HOSP. | | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE 53-00 | | | | | |
| | | | | | | D. STREET ADDRESS (If rural, give location)
535 S. MARLYN AVE - 21 | | | | | |
| 5. SEX
M | 6. RACE
W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
MARRIED | | 8. DATE OF BIRTH
7. 9. 88 | 9. AGE (In years last birthday)
78 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
ELECT. MAINT. MARINE Co. | | | | 10B. KIND OF BUSINESS OR INDUSTRY
Martin Company | | 11. BIRTHPLACE (State or foreign country)
IOWA | | | 12. CITIZEN OF WHAT COUNTRY?
AMR. | | |
| 13. FATHER'S NAME
Fredrick R. Pike | | | | | | 14. MOTHER'S MAIDEN NAME
Charlotte M Leeds | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No. | | | | 16. SOCIAL SECURITY NO.
212-03-4074 | | 17. INFORMANT
CHURCH HOME & HOSP. | | | ADDRESS | | |
| 18. 490X I CAUSE OF DEATH | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
acute myocardial infarction | | | | | | one week | | | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
acute pneumonia | | | | | | one week | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | |
| 19A. DATE OF OPERATION
0 | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 4. 16. 1967 to 4. 22. 1967 , that (I) (we) last saw the deceased alive on 4. 22. 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE
K. M. Anandath M.D. | | | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | 23B. DATE SIGNED
4/22/67. | | |
| 23C. PHYSICIAN'S NAME (Type)
K-M. ANANDATH M.D. | | | | | | 23D. ADDRESS
Church home & hospital Baltimore Md. | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
4-26-1967 | | 24C. NAME of CEMETERY or CREMATORY
Parkwood Cemetery | | 24D. LOCATION (City, town, or county) (State)
Baltimore Co. Md. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 25 1967 | | 25B. NAME OF REGISTRAR
Dr. E. J. F. ... | | 25C. FUNERAL DIRECTOR
Lasaghi Funeral Home 7481 Belair Road | | ADDRESS (36) | | | | | |

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FUNERAL DIRECTOR: IMPORTANT

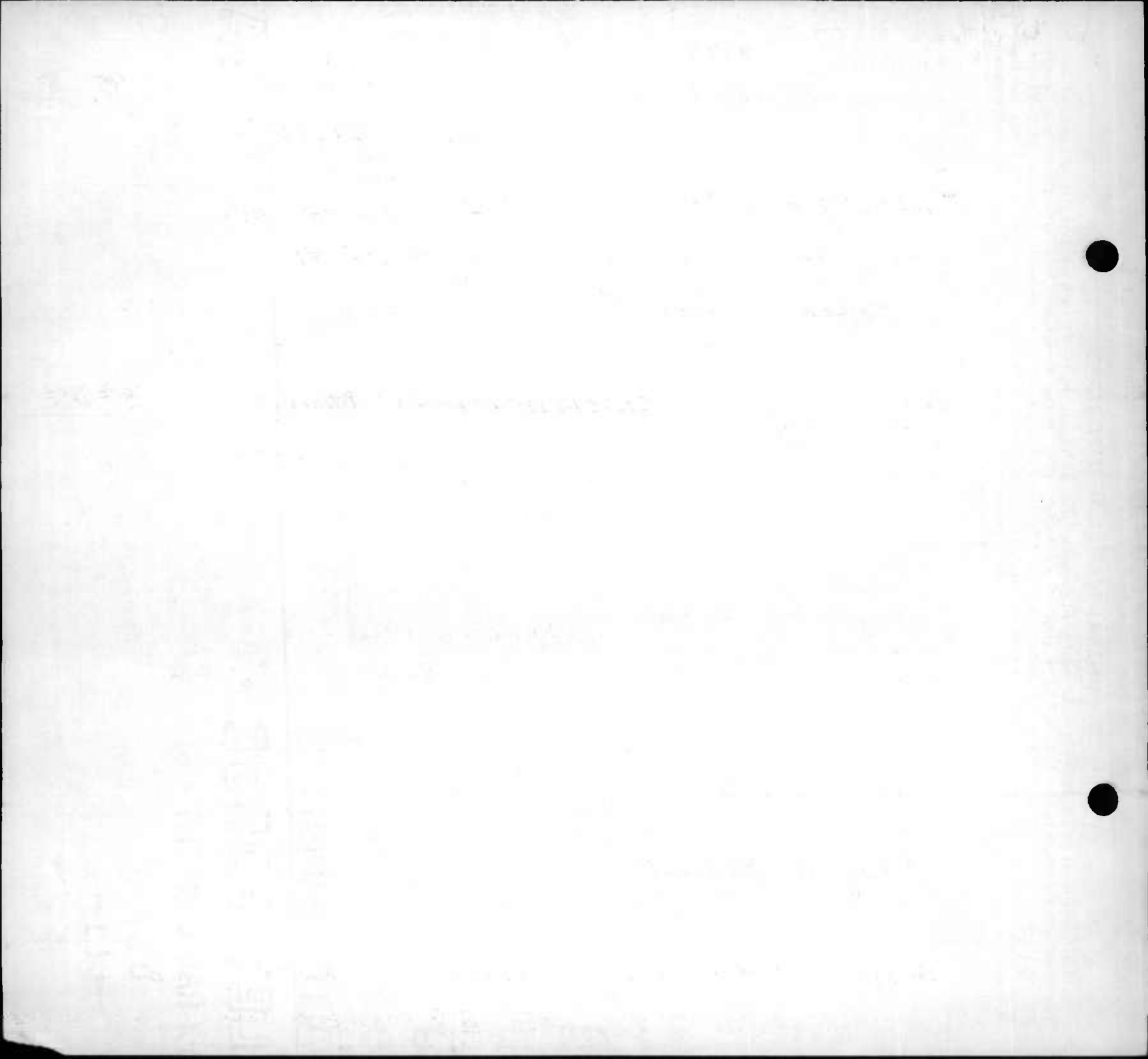
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|---|-------------------------|---|-------------------------------------|--|---|
| BIRTH NO. 67 4053 | | CERTIFICATE OF DEATH | | Registered No. 67 4053 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) WILLIAM H. FEEHLEY | | 2. DATE AND HOUR OF DEATH
4-22-67 1225 PM | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD. B. COUNTY BALTIMORE | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
48 MARYLAND GENERAL HOSP. BALTO., MD. | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
DUNDALK #21222. | | | |
| | | D. STREET ADDRESS (If rural, give location)
1768 BROOKVIEW RD. | | | |
| 5. SEX
MALE | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
MARRIED | 8. DATE OF BIRTH
12-12-11 | 9. AGE (In years lost birthday)
55 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
RR. MAIL CLERK U.S. MAIL | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
MD. BALTO. CO. | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A | | 13. FATHER'S NAME
TIMOTHY FEEHLEY | | 14. MOTHER'S MAIDEN NAME
FRANCES BANDY | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
YES W. W. II | | 16. SOCIAL SECURITY NO.
218-18-5165 | | 17. INFORMANT
WIFE ABOVE | |
| 18. 193.0 I | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) GLIOBLASTOMA MULTIFORME | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO | | | |
| | | (C) | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
4-20-67 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
GLIOBLASTOMA (BRAIN TUMOR) | | 20A. AUTOPSY? (Yes or No)
NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from 4-15 19 67 to 4-22 19 67 , that (1) (we) lost saw the deceased alive on 4-22 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
GARY L. NOBEL | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
4-22-67 | |
| 23C. PHYSICIAN'S NAME (Type)
GARY L. NOBEL | | 23D. ADDRESS
2903-A ANOORRA BALTO MD | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
4-26-67 | | 24C. NAME OF CEMETERY or CREMATORY
ZION EVANGELICAL LUTHERAN | |
| | | | | 24D. LOCATION (City, town, or county) (State)
GOLDEN RING, MD. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR
Charles J. Feiler | | 25C. FUNERAL DIRECTOR
901 S. CONKLING ST. BALTO., MD. | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | |
|---|-----------|---|--|--|--|--|---|--------------------------|---|---|--|
| Certificate of Death | | | | | Registered No. 67 4054 | | | | | | |
| BIRTH NO. 67 4054 | | M.E. CASE NO. | | | 1. NAME OF DECEASED (Type or Print) JOSEPH BURNIS. | | | | | 2. DATE AND HOUR OF DEATH 4-20-67 5:15 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 37 MERCY HOSPITAL | | | | | A. STATE MD. BALTO. Co. | | | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) DUNDALK 53-00 | | | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location) 6730 RAILWAY AVE | | | | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED | | | 8. DATE OF BIRTH May 14-1885 | | 9. AGE (In years last birthday) 81 | | 10. Under 1 Yr. Months: Days: Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TAILOR | | | 10B. KIND OF BUSINESS OR INDUSTRY CALVERT-CLOTHES | | | 11. BIRTHPLACE (State or foreign country) LITHUANIA | | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13. FATHER'S NAME | | | | | 14. MOTHER'S MAIDEN NAME | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN | | | | | 16. SOCIAL SECURITY NO. 215-01-0535 | | 17. INFORMANT DOROTHY BRASKIS | | | ADDRESS SAME | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) | | | | | CAUSE OF DEATH | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES | | | | | (A) POSSIBLE MYOCARDIAL INFARCTION DUE TO OR VENTRICULAR FIBRILLATION | | | | | MIN | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | (B) ARTERIOCLEROTIC VASCULAR DISEASE DUE TO | | | | | YRS. | |
| | | | | | (C) STROKE | | | | | | |
| II | | | | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. DIABETES MELLITUS | | | | | YRS. | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? III in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 4-4 1967 to 4-20 1967, that (I) (we) lost saw the deceased alive on 4-20- 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE Jay M. Bauwark | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | 23B. DATE SIGNED 4-20-67 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | | 23D. ADDRESS M.D. | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 4/24/67 | | 24C. NAME OF CEMETERY or CREMATORY HOLY REDEEMER | | | 24D. LOCATION BALTO. MD | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | | 25B. NAME OF REGISTRAR | | | 25C. FUNERAL DIRECTOR J.E. CONNELLY SONS | | | ADDRESS 300 MAG | | |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. **67 4055**BIRTH NO. **67 4055**

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)**PIERCE G. ALTSCHUL**

2. DATE AND HOUR PRONOUNCED DEAD

April 22, 1967 5:00 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)**00 820 Park Avenue**4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY**Maryland**

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

820 Park Avenue

5. SEX

Male

6. RACE

White7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)**never married**

8. DATE OF BIRTH

18989. AGE (In years
last birthday)**70**If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

Printer

11. BIRTHPLACE (State or foreign country)

Bucylus, Ohio12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

Henry Altschul

14. MOTHER'S MAIDEN NAME

Rebecca Sachs15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)**no**16. SOCIAL
SECURITY NO.**382-10-2607**

17. INFORMANT

**Mrs. Hilda Kearns 425 W. Bancroft St.
Toledo, Ohio**

ADDRESS

420.0

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) **Arteriosclerotic heart disease**
DUE TOANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) _____
DUE TO

(C) _____

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT NOT WHILE
WORK AT WORK

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)**Charles S. Springate, M.D.**

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

April 23, 196723A. BURIAL CREMATION,
REMOVAL (Specify)**Burial**

23B. DATE

4/24/67

23C. NAME OF CEMETERY or CREMATORY

Har Sinai

23D. LOCATION

(City, town, or county)

(State)

Erdman Ave. Baltimore

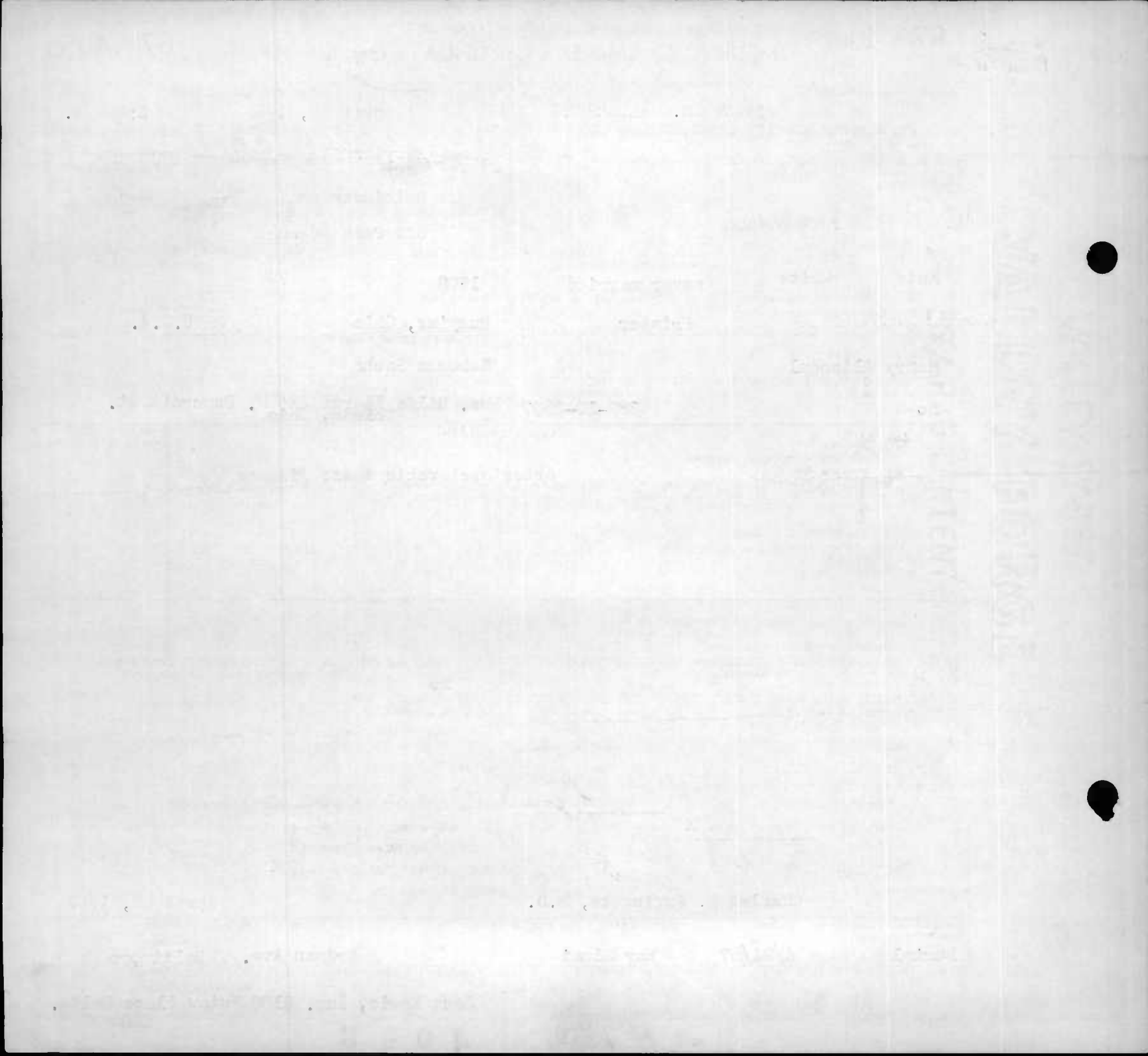
24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

APR 25 1967**Robert E. Fashy****Jack Lewis, Inc. 2100 Eutaw Place Balto.**



1
C-400

67 4056

BALTIMORE CITY HEALTH DEPARTMENT

67 4056

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JOSEPH P. CALLOWAY

2. DATE AND HOUR PRONOUNCED DEAD

4-16-67

8:30 AM M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

00 11 NORTH SPRING STREET

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

11 N. Spring Street

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Divorced

8. DATE OF BIRTH

1-5-1912

9. AGE (In years
last birthday)

55

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Labourer

10B. KIND OF BUSINESS OR INDUSTRY

BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Lafayette Calloway

14. MOTHER'S MAIDEN NAME

Annie Merritt

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

157-01-4846

17. INFORMANT

ADDRESS

Helen Saunders - 2818 W. Mulberry ST

18. 491X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Hemorrhagic bronchopneumonia

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Pulmonary scarring and emphysema

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)

WERNER U. SPITZ, M.D.

CHIEF MEDICAL EXAMINER ☐

M.D. ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4-16-67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

4-24-67

23C. NAME OF CEMETERY OR CREMATORY

Mt Auburn

23D. LOCATION

Balts.

(City, town, or county)

(State)

Md.

24A. DATE REC'D BY HEALTH DEPT.

APR 25 1967

24B. NAME OF REGISTRAR

Robert E. Fisher

24C. FUNERAL DIRECTOR

Durnell B. Oden Balto. Md.

ADDRESS

[Faint, illegible handwriting throughout the page, possibly bleed-through from the reverse side. Some words like "Bureau" and "Department" are faintly visible.]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 4057 | |
|---|---------------------|--|-----------------------------------|---|---|
| CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. 67 4057 | | | | | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED
(Type or Print) Wilson, Willie | | 2. DATE AND HOUR OF DEATH
DOA 22 April 67 11:18 AM M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

University of Maryland Hospital
<small>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)</small> | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY Baltimore City | | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | | D. STREET ADDRESS (If rural, give location)
803 Edmondson Avenue | | | |
| 5. SEX
M | 6. RACE
N | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married m | 8. DATE OF BIRTH
9/1/06 | 9. AGE (In years last birthday)
60, 1906 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
unknown | | 10B. KIND OF BUSINESS OR INDUSTRY
Laborer/Antique Act. | | 11. BIRTHPLACE (State or foreign country)
USA | |
| 13. FATHER'S NAME
unknown James Wilson | | 14. MOTHER'S MAIDEN NAME
*unknown Roseibell Page | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
unknown | | 16. SOCIAL SECURITY NO.
213-03-8522 | | 17. INFORMANT ADDRESS
Old chart | |
| 18. 141.01
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) Hemorrhagic shock
DUE TO
(B) Cancer of base of tongue
DUE TO
(C) | | INTERVAL BETWEEN ONSET AND DEATH
est 12 hr
more than 15 mo. | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
D | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
1501 85th | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Dec 2 19 66 to April 4 19 67 , that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Sidney Stapleton | | | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type)
SIDNEY STAPLETON | | | | 23D. ADDRESS
UNIVERSITY HOSPITAL | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
3/26/67 | | 24C. NAME OF CEMETERY or CREMATORY
Mt. Calvary Cemetery | |
| 24D. LOCATION
Cedar Hill Maryland | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 25 1967 | | 25B. NAME OF REGISTRAR
Robert E. Farley | | 25C. FUNERAL DIRECTOR ADDRESS
Donald E. Glover 1701-03 Patterson Pk. | |

WILSON'S

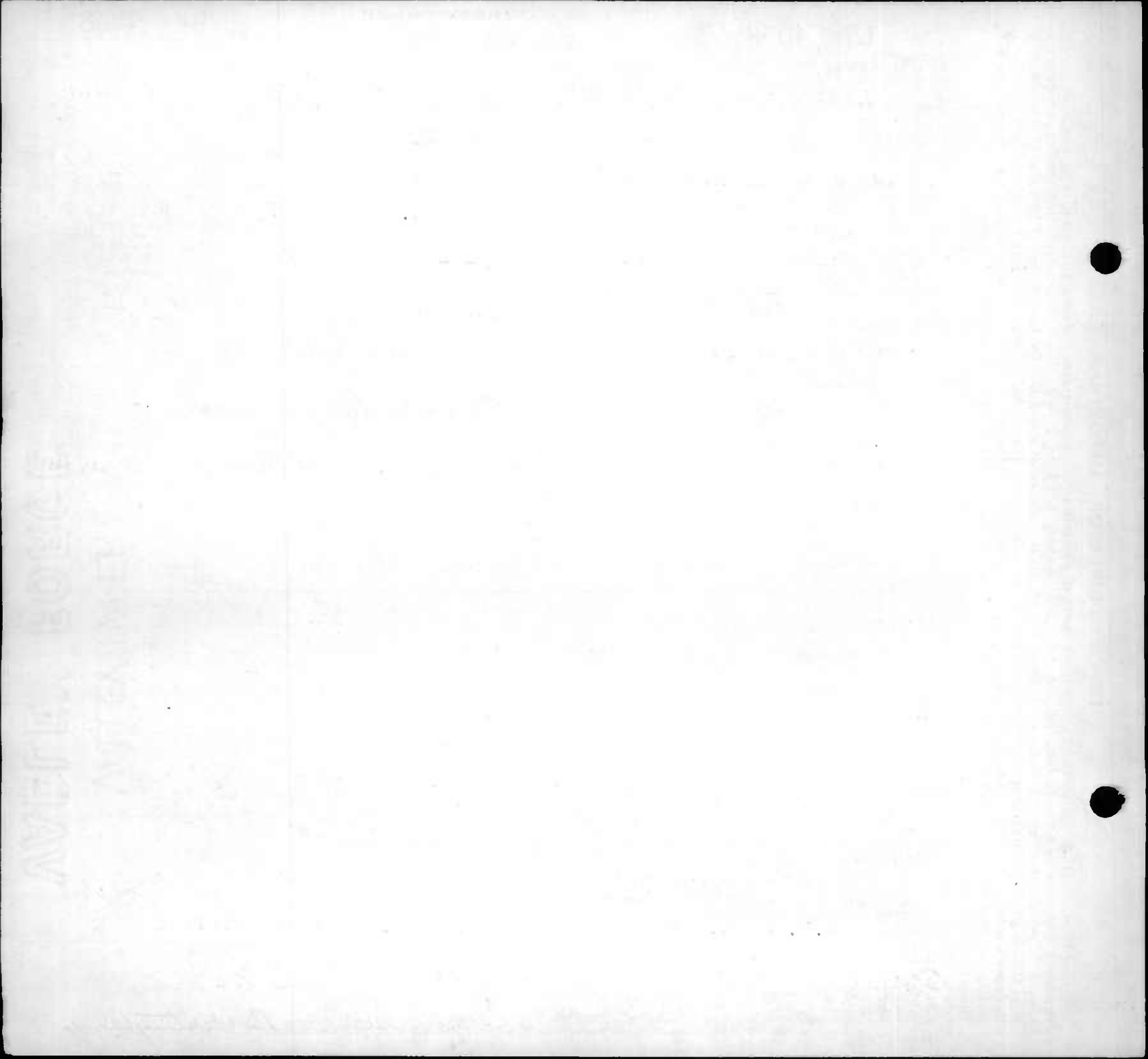
— *W. C. Wilson* —
WILSON'S

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 4058 | |
|---|-------------------------|---|---|---|---|
| BIRTH NO. 67 4058 | | | | | |
| CERTIFICATE OF DEATH | | | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) <u>Robinson, William</u> | | 2. DATE AND HOUR OF DEATH
<u>4/21/67</u> <u>3³⁰</u> <u>Am</u> M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<u>THE JOHNS HOPKINS HOSPITAL</u>
<u>33</u> | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <u>MARYLAND</u>
B. COUNTY <u>BALTIMORE</u>
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u>
D. STREET ADDRESS (If rural, give location) <u>817 N. DALLAS ST</u>
<u>7-05</u> | | |
| 5. SEX
<u>MALE</u> | 6. RACE
<u>NEGRO</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
<u>MARRIED</u> | 8. DATE OF BIRTH
<u>2-2-21</u> | 9. AGE (In years last birthday)
<u>46</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Retired</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>VA</u> | |
| 13. FATHER'S NAME
<u>BENJAMINE ROBINSON</u> | | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>no</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
<u>Source Only</u> <u>Law</u> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
<u>162.1+260X</u> | | CAUSE OF DEATH
(A) DUE TO <u>BRONCHOGENIC CARCINOMA</u>
(B) DUE TO <u>BRONCHOPNEUMONIA</u>
(C) DUE TO <u>DIABETES MELLITUS</u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>18 mos.</u>
<u>1 wk.</u>
<u>2 yrs.</u> | |
| II
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
<u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<u>Yes</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>4/21/67</u> to <u>4/21/67</u> , that (I) (we) last saw the deceased alive on <u>4/21/67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) did (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>C.H. Brown, III</u> | | | | 23B. DATE SIGNED
<u>4/21/67</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>C.H. BROWN, 3RD</u> | | | | 23D. ADDRESS
<u>THE JOHNS HOPKINS HOSPITAL</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>4-25-67</u> | | 24C. NAME OF CEMETERY OR CREMATORY
<u>Mt Arlem Cent</u> | |
| 24D. LOCATION (City, town, or county)
<u>Baltimore</u> | | 24E. (State)
<u>MD</u> | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>APR 25 1967</u> | | 25B. NAME OF REGISTRAR
<u>Robert E. Farber</u> | | 25C. FUNERAL DIRECTOR
<u>Elmer W. Brown 1801 Broomfield Ave</u> | |



49-0418

K-152 67 4059

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 67 4059

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Benjamin ROBINSON L.

2. DATE AND HOUR OF DEATH

4-20-67

2:41 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)BALTIMORE CITY HOSPITALS
4940 EASTERN AVENUE
BALTIMORE, MARYLAND 212244. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE B. COUNTY

MARYLAND

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

BALTIMORE

D. STREET ADDRESS (If rural, give location)

1116 BARCLAY STREET - BALTIMORE, MD.

5. SEX

MALE

6. RACE

NEGRO

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

SEPERATED

8. DATE OF BIRTH

6-3-21

9. AGE (In years
last birthday)

45

If Under 1 Yr.

Months Days

If Under 24 Hrs.

Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Labor

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

LOUIS ROBINSON

14. MOTHER'S MAIDEN NAME

ELEANORE Smitt

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

YES

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

RECORDS-BCH-4940 EASTERN AVENUE, 21224

18.

445X1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(A) Malignant Hypertension

Months

(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

DUE TO

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

YES

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (the hospital) attended the deceased from 4-9-67 to 4-20-67
that (I) (we) last saw the deceased alive on 4-19-67 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

23A. SIGNATURE

David J. Mishelevich

M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

4-20-67

23C. PHYSICIAN'S
NAME (Type)

DR. DAVID J. MISHELEVICH

M.D.

23D. ADDRESS

21224

BCH-4940 EASTERN AVENUE, BALTIMORE, MD.

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

4-25-67

24C. NAME OF CEMETERY or CREMATORY

Baltimore Nat Cent

24D. LOCATION

Baltimore

(City, town, or county)

(State)

Md

25A. DATE REC'D BY HEALTH DEPT.

APR 25 1967

25B. NAME OF REGISTRAR

R. E. Feltner

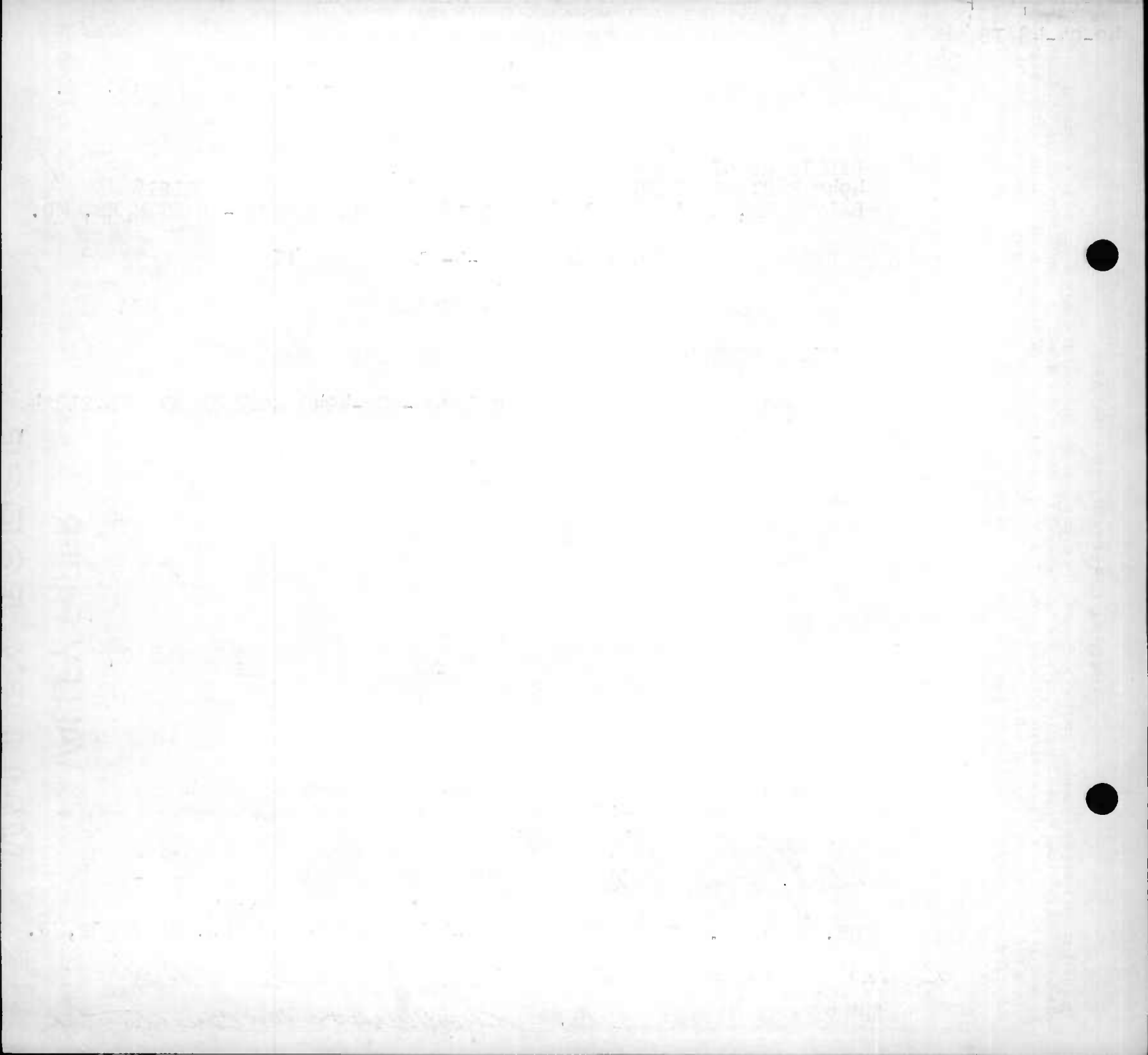
25C. FUNERAL DIRECTOR

Gray Wilson & Son

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | Registered No. <u>67 4060</u> | |
|--|---------------------|--|---|---|--|--|--|
| BIRTH NO. <u>67 4060</u> | | M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) <u>Daniel Ringgold</u> | | 2. DATE AND HOUR OF DEATH
<u>April 18, 1967</u> <u>8:15 P. M.</u> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>818 Chaucery ST.</u>
<u>00</u> | | | | A. STATE
<u>Maryland</u> | | B. COUNTY
<u>Baltimore</u> | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>Baltimore</u> | | D. STREET ADDRESS (If rural, give location)
<u>818 Chaucery Street</u> | |
| 5. SEX
<u>Male</u> | 6. RACE
<u>C</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)
<u>Married</u> | 8. DATE OF BIRTH
<u>10-13-94</u> | 9. AGE (In years last birthday)
<u>72</u> | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Retired</u> | | 11. CITIZEN OF WHAT COUNTRY?
<u>USA</u> |
| 13. FATHER'S NAME
<u>George Ringgold</u> | | | 14. MOTHER'S MAIDEN NAME
<u>Bertha</u> | | | 15. Was Deceased Ever in U. S. Armed Forces (Yes, no or unknown) (If yes, give war or dates of service)
<u>No</u> | |
| 16. SOCIAL SECURITY NO.
<u>213-03-7484-A</u> | | | 17. INFORMANT
<u>Comden Ringgold</u> | | | | ADDRESS
<u>Same</u> |
| 18. <u>163 X I</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
<u>Undifferentiated Carcinoma Lung</u> | | | | CAUSE OF DEATH
(A) DUE TO
(B) DUE TO
(C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH
<u>> 7 mo.</u> | |
| 19. DATE OF OPERATION
<u>0</u> | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<u>No</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)
(APPROX.) | | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>Oct 13</u> 19 <u>66</u> to <u>April 18</u> 19 <u>67</u> , that (I) <u>(we)</u> lost saw the deceased alive on <u>March 24</u> 19 <u>67</u> and that in <u>(my)</u> <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(We)</u> <u>(did)</u> <u>(did not)</u> view the body after death. | | | | | | | |
| 23A. SIGNATURE
<u>W. Michael Gould</u> | | | | 23B. DATE SIGNED
<u>4/18/67</u> | | 23C. PHYSICIAN'S NAME (Type)
<u>W. Michael Gould</u> | |
| 23D. ADDRESS
<u>M.D. Maryland General Hospital Balto. Md.</u> | | | | 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | | |
| 24B. DATE
<u>4-22-67</u> | | | | 24C. NAME OF CEMETERY OR CREMATORY
<u>Mt Calvary Cont</u> | | 24D. LOCATION (City, town, or county) (State)
<u>B. A. C. Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>APR 25 1967</u> | | | | 25B. NAME OF REGISTRAR
<u>Robert E. Taylor</u> | | 25C. FUNERAL DIRECTOR
<u>Shirley D. Wilson</u> | |
| | | | | ADDRESS
<u>1000 Brimley Ave.</u> | | | |

April 1947

Don't know

818 January 27

that these tests concern land & sea

100
100
100
100

April 12

Oct 12
March 24

W. Michael

X

W. Michael

M-160

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO.

67 4061

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

67 4061

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

WILLIAM C.

MAYBERRY

2. DATE AND HOUR PRONOUNCED DEAD

April 21, 1967

11:45 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

1522 W. Fayette St.

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

310 N. Pulaski St.

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

July 22 - 1932

9. AGE (In years
last birthday)

35

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Labor

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

South Carolina

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Chewey Mayberry

14. MOTHER'S MAIDEN NAME

Lillie Mae Holley

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give year or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

Lillie Mae Holley

ADDRESS

Same

18.

E 982X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

Stabwound of back

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

INTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH? Yes21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

1522 W. Fayette St.

21D. TIME OF INJURY
(APPROX.) 4-21-67 11:40 P

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Stabbed during altercation

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATURE

Charles S. Spingate

M.D.

ASSISTANT MEDICAL EXAMINER ☒EXAMINER'S
NAME (Type)

Charles S. Spingate, M.D.

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4-22-67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

4-22-67

23C. NAME OF CEMETERY or CREMATORY

Philadelphia Baptist Cal

23D. LOCATION

(City, town, or county)

South Carolina

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

APR 25 1967

11876.2670004069

WALLACE & GORING

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | | | | | | | | | |
|--|--|-----------------|--|--|--|-----------------------------------|--|---|--|--|--|------------------------------|--|--|--|--|--|--|--|
| BIRTH NO. 67 4062 | | | | | CERTIFICATE OF DEATH | | | | | Registered No. 67 4062 | | | | | | | | | |
| M.E. CASE NO. | | | | | 1. NAME OF DECEASED
(Type or Print) John T. Finnegan | | | | | 2. DATE AND HOUR OF DEATH
April 23, 1967 M. | | | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY | | | | | | | | | | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location)
00 5207 Beaufort Ave. | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | | | | | D. STREET ADDRESS (If rural, give location)
5207 Beaufort Ave. | | | | | | | | | |
| 5. SEX
Male | | 6. RACE
Cau. | | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Divorced | | 8. DATE OF BIRTH
Aug. 15, 1910 | | 9. AGE (In years last birthday)
56 | | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Hours: Min. | | | | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Chauffeur | | | | 10B. KIND OF BUSINESS OR INDUSTRY
Taxie Cab | | | | 11. BIRTHPLACE (State or foreign country)
Baltimore, Md. | | | | 12. CITIZEN OF WHAT COUNTRY? | | | | | | | |
| 13. FATHER'S NAME
Charles Clifford Finnegan | | | | | 14. MOTHER'S MAIDEN NAME
Mary E. Fraunholtz | | | | | | | | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | | | 16. SOCIAL SECURITY NO.
212-03-4333 | | 17. INFORMANT
Mrs. Mary E. Finnegan, 5207 Beaufort Ave. | | | | | ADDRESS | | | | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
420.1 + 141.9
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Calceraria 7 Tongue | | | | | CAUSE OF DEATH
(A) acute myocardial infarction
(B) arteriosclerotic heart disease
(C)
INTERVAL BETWEEN ONSET AND DEATH
1 day
5 years
4 months | | | | | | | | | | | | | | |
| 19A. DATE OF OPERATION
0 | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20A. AUTOPSY? (Yes or No) | | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | 21F. HOW DID INJURY OCCUR? | | | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan 31 1961 to April 23 1967, that (I) last saw the deceased alive on April 23 1967 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | 23A. SIGNATURE
Manuel Levin | | | | | 23B. DATE SIGNED
4/24/67 | | | | |
| 23C. PHYSICIAN'S NAME (Type)
Manuel Levin, M.D. | | | | | 23D. ADDRESS
4818 Reisterstown Road | | | | | | | | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | | | | 24B. DATE
4/26/1967 | | | | | 24C. NAME OF CEMETERY or CREMATORY
Cathedral Cemetery | | | | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Md. | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 25 1967 | | | | | 25B. NAME OF REGISTRAR
Robert E. Taylor | | | | | 25C. FUNERAL DIRECTOR
G. Vernon Lemmon | | | | | ADDRESS
4611 Park Heights Ave. | | | | |

THE CHURCH

OF THE

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1943

1944

1945

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Certificate of Death | | Registered No. 385192
67 4063 | |
|--|---|--|---|---|--|--|--|
| BIRTH NO. 67 4063 | | | | 1. NAME OF DECEASED
(Type or Print) SADIE C. CHETELAT | | 2. DATE AND HOUR OF DEATH
4/24/67 10 15 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Sinai Hospital of Baltimore Inc | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY BALTIMORE
C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE
D. STREET ADDRESS (If rural, give location) 4707 Park Heights Ave | | | |
| 5. SEX
FEMALE | 6. RACE
CAUC. | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
MARRIED | 8. DATE OF BIRTH
9.1.92 | 9. AGE (In years last birthday)
74 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 11. BIRTHPLACE (State or foreign country)
Baltimore, Md. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY
At Home | | 11. BIRTHPLACE (State or foreign country)
Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME
William Freamer | | | | 14. MOTHER'S MAIDEN NAME
Minnie Homan | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
214-20-3097B | | 17. INFORMANT
Hosp. Rec. | | ADDRESS | |
| 18. 443X
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Cerebro Vascular Accident
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Hypertensive C.V. disease
Generalized arteriosclerosis | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from April 19 1967 to April 24 1967 , that (I) (we) last saw the deceased alive on April 24 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
Nathan E. Needle M.D. | | | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
4-24-67 | |
| 23C. PHYSICIAN'S NAME (Type)
NATHAN E. NEEDLE M.D. | | | | 23D. ADDRESS
6506-Park Hgts Rd Baltimore, Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
4/27/67 | | 24C. NAME OF CEMETERY or CREMATORY
Baltimore, National Cemetery | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 25 1967 | | 25B. NAME OF REGISTRAR
Robert E. Johnson | | 25C. FUNERAL DIRECTOR
B. Vernon Lemmon | | ADDRESS
4611 Park Heights Ave. | |

STATE OF CALIFORNIA

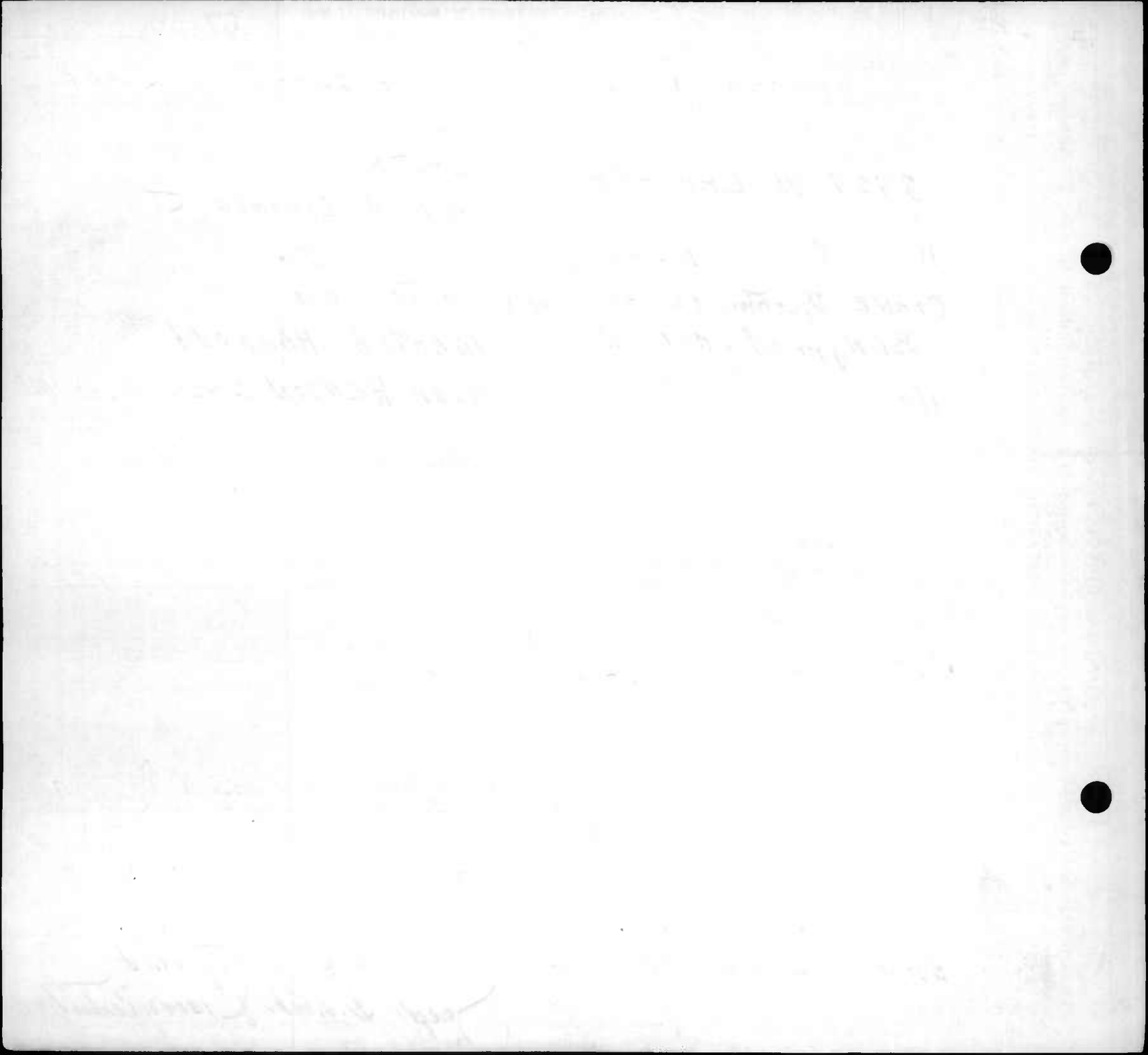
Franklin County

Wm

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Certificate of Death | | Registered No. 67 4064 | |
|---|----------------------|--|-------------------------------------|--|----------------------------|--|-----------------------------|
| BIRTH NO. 67 4064 | | | | | | | |
| M.E. CASE NO. | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) HOWARD N. HENSON | | | | 2. DATE AND HOUR OF DEATH
4-22-67 5:10 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
2427 W. LANVALE | | | | A. STATE MD
B. COUNTY | | | |
| (If not in hospital or institution, give street address or location) | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTO. | | | |
| | | | | D. STREET ADDRESS (If rural, give location)
2427 W. LANVALE ST | | | |
| 5. SEX
M. | 6. RACE
C. | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
MARRIED | 8. DATE OF BIRTH
12-12-12 | 9. AGE (In years last birthday)
54 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
CRANE OPERATOR | | 10B. KIND OF BUSINESS OR INDUSTRY
REVERE COPPER | | 11. BIRTHPLACE (State or foreign country)
BALTO. MD. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME
BENJAMIN HENSON | | | | 14. MOTHER'S MAIDEN NAME
MARTHA HAMMOND | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
ELIZA HENSON 2427 W. LANVALE | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)
CAUSE OF DEATH
Carcinoma of the lung | | | | INTERVAL BETWEEN ONSET AND DEATH
4 months | | | |
| 19A. DATE OF OPERATION
January 1967 | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
Cancer of lung - inoperable | | 20A. AUTOPSY? (Yes or No)
No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from December 29 19 66 to April 21 19 67 , that (I) (we) last saw the deceased alive on April 21st 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) DID NOT (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
Crawford N. Kirkpatrick, Jr. | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
April 24, 1967 | |
| 23C. PHYSICIAN'S NAME (Type)
Crawford N. Kirkpatrick, Jr. | | | | 23D. ADDRESS
6 East Eager Street Baltimore, Md. 21202 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
4/27/67 | | 24C. NAME of CEMETERY or CREMATORY
MT. CALVARY | | 24D. LOCATION (City, town, or county) (State)
A.A. County, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 25 1967 | | 25B. NAME OF REGISTRAR
Alfred E. Taylor | | 25C. FUNERAL DIRECTOR
Joseph B. Rock | | ADDRESS
1304 W. Central Ave | |



FUNERAL DIRECTOR: IMPORTANT

RGB

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|-------------|--|--------------------------|--|---|
| BIRTH NO. 67 4065 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 4065 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) Charles Edward Dobson | | 2. DATE AND HOUR OF DEATH
April 23, 1967 5:42 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
US Public Health Service Hospital
Wyman Pk. Drive & 31st Street | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE Ga.
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Savannah
D. STREET ADDRESS (If rural, give location) 223 W. 31st Street | | | |
| 5. SEX M | 6. RACE Col | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widower | 8. DATE OF BIRTH 3/25/10 | 9. AGE (In years last birthday) 57 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Wiper | | 10B. KIND OF BUSINESS OR INDUSTRY Seafarer | | 11. BIRTHPLACE (State or foreign country) Ga. Savannah | |
| 13. FATHER'S NAME Charles Dobson | | 14. MOTHER'S MAIDEN NAME Mattie Lloyd | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 067-03-7580 | | 17. INFORMANT ADDRESS Records- US PHS Hospital, Balto, Md. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
Acute passive congestion | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH Days | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) DUE TO
(B) DUE TO
(C) DUE TO | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | Cancer of the esophagus | | Months | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from Jan. 4 1967 to Apr. 23 1967, that (1) (we) last saw the deceased alive on Apr. 23 1967 and that in (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Michael E. Pelczar, M.D. | | | | 23B. DATE SIGNED 4/24/67 | |
| 23C. PHYSICIAN'S NAME (Type) Michael E. Pelczar, SA Surg (R) | | | | 23D. ADDRESS US PHS Hospital, Balto, Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Removal | | 24B. DATE 4/25/67 | | 24C. NAME OF CEMETERY or CREMATORY | |
| 25A. DATE REC'D BY HEALTH DEPT. APR 25 1967 | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| | | | | 24D. LOCATION (City, town, or county) (State) New York, N.Y. | |
| | | | | ADDRESS | |

Michael E. DeLoach

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. | |
|---|-----------------------------|--|---|--|---|
| BIRTH NO. 67 4066 | | CERTIFICATE OF DEATH | | 67 4066 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) Gertrude Randall | | 2. DATE AND HOUR OF DEATH
April 23, 1967 M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
90 KENSON
2922 Arunah Ave. | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
2854 Rayner Ave | | | |
| 5. SEX
Female | 6. RACE
Colored | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH
Mzy 20, 1891 | 9. AGE (In years last birthday)
75 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Domestic | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 13. FATHER'S NAME
George A. Smith | | 14. MOTHER'S MAIDEN NAME
Nancy Chisley | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Mrs. Maude Joyce ADDRESS
2854 Rayner Acc. | |
| 18. 4221 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
Cold - vasculitis
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) DUE TO
Cold - vasculitis
(B) DUE TO
(C) | | INTERVAL BETWEEN ONSET AND DEATH
UNKNOWN | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 10-31-1957 to 4-23-1967 , that (I) (we) last saw the deceased alive on 4-19-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
William H. Watts | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
4-24-67 | |
| 23C. PHYSICIAN'S NAME (Type)
William H. Watts | | 23D. ADDRESS
3211 Arbutus Ave. Baltimore Md 21222 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | 24B. DATE
4-27-67 | 24C. NAME of CEMETERY or CREMATORY
Arbutus Mem. Park | | 24D. LOCATION (City, town, or county) (State)
Arbutus, Balto. Co., Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 23 1967 | | 25B. NAME OF REGISTRAR
Robert E. Taylor | | 25C. FUNERAL DIRECTOR
Mrs. Frances A. Remick ADDRESS
578 W. Biddle St. | |

1941, 12, 15

1941, 12, 15

1941, 12, 15

1941, 12, 15

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1941, 12, 15

W-300

67 4067

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 4067

M.E. CASE NO.

| | | | |
|---|---------------------------|---|---|
| 1. NAME OF DECEASED
(Type or Print)
REBECCA WHITE | | 2. DATE AND HOUR PRONOUNCED DEAD
4-21-67 11:50 AM | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
2132 VINE STREET - Amb. Crew #8 | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE Maryland
B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 20-02
D. STREET ADDRESS (If rural, give location)
2132 Vine Street, Baltimore 21223 | |
| 5. SEX
Female | 6. RACE
Colored | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)
Married | 8. DATE OF BIRTH
58 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country)
Baltimore |
| 13. FATHER'S NAME
Phillips | | 14. MOTHER'S MAIDEN NAME
Mzry Sharp | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT
Harold White 2132 Vine St. |

| | | | |
|---|--|--|--|
| 18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
Arteriosclerotic cardiovascular disease
DUE TO
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION
4-22-67 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No)
No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | |
| 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>
ACTUAL SIGNATURE Werner U. Spitz M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>
EXAMINER'S NAME (Type) WERNER U. SPITZ, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 4-21-67 | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 23B. DATE
4-26-67 | |
| 23C. NAME OF CEMETERY or CREMATORY
Carver MemPark | | 23D. LOCATION (City, town, or county) (State)
Laurel Md. | |
| 24A. DATE REC'D BY HEALTH DEPT.
APR 25 1967 | | 24B. NAME OF REGISTRAR
Robert E. Taylor | |
| 24C. FUNERAL DIRECTOR
Mr. Francis A. Hemmley | | 24D. ADDRESS 578 W Biddle St | |

1 9 6 7 0 0 0 4 0 7 1 5

57-100-10000



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|-------------------------|--|-----------------------------------|--|---|
| BIRTH NO. 67 4068 | | BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | Registered No. 67 4068 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) PEARL CLARK | | 2. DATE AND HOUR OF DEATH
4-23-67 11:30 A. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
THE JOHNS HOPKINS HOSPITAL
BALTIMORE, MD 21205 | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE VIRGINIA
C. CITY OR TOWN (If outside city limits, write RURAL and give township) APPALACHIA
D. STREET ADDRESS (If rural, give location) BOX 292 | | | |
| 5. SEX
FEMALE | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED
WIDOWED | 8. DATE OF BIRTH
9-6-91 | 9. AGE (In years last birthday)
75 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME
JAMES STURGILL | | 14. MOTHER'S MAIDEN NAME
MARGARET BARNES | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| 18. 451X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ASVD | | CAUSE OF DEATH
(A) ? Ruptured Aorta
(B) ASVD
(C) | | INTERVAL BETWEEN ONSET AND DEATH
4 hrs
years | |
| 19A. DATE OF OPERATION
4-15-67 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
colostomy | | 20A. AUTOPSY? (Yes or No)
Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that 12 (this hospital) attended the deceased from 4/18 19 67 to 4/23 19 67 , that 12 (we) last saw the deceased alive on 4/23 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. 12 (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Monica M. Buckley | | | | 23B. DATE SIGNED
4/23 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| MONICA M. BUCKLEY | | JOHNS HOPKINS HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
4-27-67 | | 24C. NAME of CEMETERY or CREMATORY
Riverview Cemetery | |
| 24D. LOCATION (City, town, or county) (State)
East Stone Gap, Virginia | | 25A. DATE REC'D BY HEALTH DEPT. | | | |
| 25B. NAME OF REGISTRAR
Howard H. Hubbard | | 25C. FUNERAL DIRECTOR ADDRESS
Howard H. Hubbard-4107 Wilkens Ave. 21229 | | | |

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

4069

67

4069

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JOHN F. O'BRIEN

2. DATE AND HOUR PRONOUNCED DEAD

4-23-67

7:44 PM M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

ST. AGNES HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

5810 Heron Avenue

21227

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

April 9, 1885

9. AGE (In years
last birthday)

82

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

Stationary Eng.

11. BIRTHPLACE (State or foreign country)

England

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

William

O'BRIEN

14. MOTHER'S MAIDEN NAME

Mary

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

036-10-8775

17. INFORMANT

ADDRESS

Florence Olney, 5810 Heron Drive

18. 443X I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) Hypertensive and arteriosclerotic

XXXX

cardiovascular disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE
AT WORK ☐

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☒

DATE SIGNED

ACTUAL
SIGNATURE

RUSSELL S. FISHER, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

4-24-67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

4/26/67

23C. NAME OF CEMETERY OR CREMATORY

Mt. St. Mary's

Pawtucket Rhode Island

23D. LOCATION

(City, town, or county)

(State)

Pawtucket, Rhode Island

24A. DATE REC'D BY HEALTH DEPT.

APR 25 1967

24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

Howard H. Hubbard 4107 Wilkens Ave.

ADDRESS

21229

JOHN G. GALT

Received of Mr. J. G. Galt the sum of \$100.00

for the purchase of the same

and the receipt of the same

is hereby acknowledged

in witness whereof

I have hereunto set my hand

and the seal of the same

this 1st day of January

1900

at the City of New York

John G. Galt

Secretary

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 4070 | |
|---|-------------------------|--|------------------------------------|---|---|
| BIRTH NO. 67-08104 4070 | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | | | 2. DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED
(Type or Print) WOOLFENDEN BABY GIRL B | | | | APRIL 21, 1967 3:20P. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION
40 ST. AGNES HOSPITAL | | | | A. STATE MARYLAND
B. COUNTY Balts. Co. | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE, MARYLAND | |
| | | | | D. STREET ADDRESS (If rural, give location)
3722 MC DOWELL LANE 21227 | |
| 5. SEX
FEMALE | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED
NEW BORN | 8. DATE OF BIRTH
4-21-67 | | 9. AGE (In years last birthday)
1 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
NEW BORN | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
BALTIMORE, MARYLAND | |
| 13. FATHER'S NAME
ROBERT B. WOOLFENDEN | | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 14. MOTHER'S MAIDEN NAME
DARRELL LYNN MILLS | |
| 16. SOCIAL SECURITY NO.
- - - | | | | 17. INFORMANT ADDRESS
ST. AGNES HOSPITAL RECORDS 21229 | |
| 18. 776X1
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. If means the disease, injury or complication which caused death.)
Immaturity - 5 mos. gestation | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (X) (this hospital) attended the deceased from APRIL 21 19 67 to APRIL 21 19 67 , that (X) (we) last saw the deceased alive on APRIL 21 19 67 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XXXX) view the body after death. | | | | | |
| 23A. SIGNATURE
<i>H. Hernandez</i> | | | | 23B. DATE SIGNED
04/21/67 | |
| 23C. PHYSICIAN'S NAME (Type)
HUMBERTO HERNANDEZ, M.D. | | | | 23D. ADDRESS
BALTO., MD. 21229
ST. AGNES HOSPITAL-CATON & WILKENS AVES. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
4/24/67 | | 24C. NAME OF CEMETERY or CREMATORY
Loudon Park Cemetery | |
| | | | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 25 1967 | | 25B. NAME OF REGISTRAR
<i>P. E. E. Farley</i> | | 25C. FUNERAL DIRECTOR ADDRESS
Howard H. Hubbard 4107 Wilkens Ave. 21229 | |

3:30

APRIL 21, 1974

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1. 1111

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U.S.A.

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | Registered No. 67 4071 | |
|--|-------------------------|--|--|--|---------------------------------|---|--|--|---|--|--|
| BIRTH NO.
67-08103 | | M.E. CASE NO.
67 4071 | | CERTIFICATE OF DEATH | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) WOOLFENDEN BABY GIRL A | | | | 2. DATE AND HOUR OF DEATH
APRIL 21, 1967 2:20P | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE MARYLAND
B. COUNTY Balt Co. | | | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
40 ST. AGNES HOSPITAL | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE | | | | | | | |
| | | | | D. STREET ADDRESS (If rural, give location)
3722 MC DOWELL LANE 21227 | | | | | | | |
| 5. SEX
FEMALE | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED
NEW BORN | | 8. DATE OF BIRTH
4-21-67 | 9. AGE (In years last birthday) | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | 35 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
NEW BORN | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
BALTIMORE, MARYLAND | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | |
| 13. FATHER'S NAME
ROBERT B. WOOLFENDEN | | | | 14. MOTHER'S MAIDEN NAME
DARRELL LYNN MILLS | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO.
- - - - - | | 17. INFORMANT
ST. AGNES HOSPITAL RECORDS | | | ADDRESS
21229 | | |
| 18. 776X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH
Immaturity - 5 mos. gestation | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| | | | | (A) DUE TO | | | | | | | |
| | | | | (B) DUE TO | | | | | | | |
| | | | | (C) DUE TO | | | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | |
| 19A. DATE OF OPERATION
0 | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from APRIL 21 1967 to APRIL 21 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on APRIL 21 1967 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> (not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE
H. Hernandez | | | | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
04/21/67 | |
| 23C. PHYSICIAN'S NAME (Type)
HUMBERTO HENANDEZ, M.D. | | | | 23D. ADDRESS
BALTO., MD. 21229 ST. AGNES HOSPITAL-CATON & WILKENS AVES. | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
4/24/67 | | 24C. NAME OF CEMETERY or CREMATORY
Loudon Park Cemetery | | | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 25 1967 | | | | 25B. NAME OF REGISTRAR
Robert E. Taylor, M.D. | | | | 25C. FUNERAL DIRECTOR
Howard H. Hubbard | | | |
| | | | | ADDRESS
4107 Wilkens Ave. 21229 | | | | | | | |

100:2

WALL, J. L.

RECEIVED IN 1911

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WALL, J. L.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 4072

BIRTH NO. 67 4072

M.E. CASE NO. D-600
D-200

| | | | |
|--|-------------------------|---|--|
| 1. NAME OF DECEASED
(Type or Print) WINFORD DYER (DYKE) | | 2. DATE AND HOUR PRONOUNCED DEAD
April 21, 1967 9:45 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

836 N. Fulton Ave. | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
836 N. Fulton Ave. | |
| 5. SEX
Male | 6. RACE
Negro | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
Married-Sep. | 8. DATE OF BIRTH
4-6-1928 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
LABORER | | 10B. KIND OF BUSINESS OR INDUSTRY | 9. AGE (In years last birthday)
39 |
| 11. BIRTHPLACE (State or foreign country)
GREENVILLE, NORTH CAROLINA U.S.A. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME
UNK. | | 14. MOTHER'S MAIDEN NAME
PATTIE LYNCH | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
Mrs. Clestia Adams | | ADDRESS
4010 Fairfax Rd. | |

| | | |
|---|--|----------------------------------|
| 18. CAUSE OF DEATH
Stabwound of chest
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | INTERVAL BETWEEN ONSET AND DEATH |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| | | | |
|---|--|---|--|
| 19A. DATE OF OPERATION
2 | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No)
Yes | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
Yes |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
Home | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
Basement Apt, 836 N. Fulton Ave. 16-04 | |
| 21D. TIME OF INJURY (APPROX.)
4-21-67 9:00 P. | 21E. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | 21F. HOW DID INJURY OCCUR?
Stabbed during altercation | |
| 22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>

ACTUAL SIGNATURE Charles S. Springate M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>
EXAMINER'S NAME (Type) Charles S. Springate, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 4-22-67 | | | |

| | | | |
|---|--|--|---|
| 23A. BURIAL CREMATION, REMOVAL (Specify)
Burial | 23B. DATE
4-26-67 | 23C. NAME of CEMETERY or CREMATORY
Mt. Auburn Cemetery | 23D. LOCATION (City, town, or county) (State)
Baltimore, Maryland |
| 24A. DATE REC'D BY HEALTH DEPT.
APR 25 1967 | 24B. NAME OF REGISTRAR
MORTON & DYETT F.H. | 24C. FUNERAL DIRECTOR ADDRESS
1701 Laurens St. | |

VALLEY POLICE

VALLEY POLICE

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death. Such deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 4073 | |
|--|------------------|---|--|---------------------------------------|---|
| M-246 67 4073 | | | | BIRTH NO. | |
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED
(Type or Print)
Hattie McClary | | | 2. DATE AND HOUR OF DEATH
4/22/67 2:00 P. M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address at location)
BALTIMORE CITY HOSPITALS
4940 Eastern Avenue
Baltimore, Maryland 21224
31 | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE
D. STREET ADDRESS (If rural, give location)
3206 W. Baltimore Street - 21229 | | |
| 5. SEX
FEMALE | 6. RACE
NEGRO | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
WIDOWED | 8. DATE OF BIRTH
8/10/99 | 9. AGE (In years last birthday)
67 | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
SOUTH CAROLINA |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 13. FATHER'S NAME
COOPER PASLEY | | |
| 14. MOTHER'S MAIDEN NAME
IDA SUSANNE PASLEY | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | |
| 16. SOCIAL SECURITY NO. | | | 17. INFORMANT ADDRESS
RECORDS: BCH, 4940 Eastern Ave., Balto. Md. 21224 | | |
| 18. 260X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | CAUSE OF DEATH
(A) Chr. Renal Failure
DUE TO
(B) HASOVD with Congestive Hrt. failure
DUE TO
(C) Diabetes and R hemiplegia with L hemiparesis
INTERVAL BETWEEN ONSET AND DEATH
5 yrs
5-6 mths
? | | |
| 19A. DATE OF OPERATION
0 | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | |
| 20A. AUTOPSY? (Yes or No)
NO | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that (I) (this hospital) attended the deceased from 4/15/67 19 to 4/22/67 19, that (I) (we) last saw the deceased alive on 4/20/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | 23A. SIGNATURE
Bruce M. Dow
M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | |
| 23B. DATE SIGNED
4/22/67 | | | 23C. PHYSICIAN'S NAME (Type)
BRUCE M. DOW | | |
| 23D. ADDRESS
BCH 4940 Eastern Avenue
Baltimore, Maryland 21224 | | | 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | |
| 24B. DATE
4-28-67 | | | 24C. NAME OF CEMETERY or CREMATORY
Mt. Zion church Cem. | | |
| 24D. LOCATION (City, town, or county) (State)
Greensville, South Carolina | | | 25A. DATE REC'D BY HEALTH DEPT.
APR 25 1967 | | |
| 25B. NAME OF REGISTRAR
Robert E. Taylor | | | 25C. FUNERAL DIRECTOR ADDRESS
MORTON & DYETT F.H. 1701 Laurens St. | | |

रमेशचंद्र

रमेशचंद्र



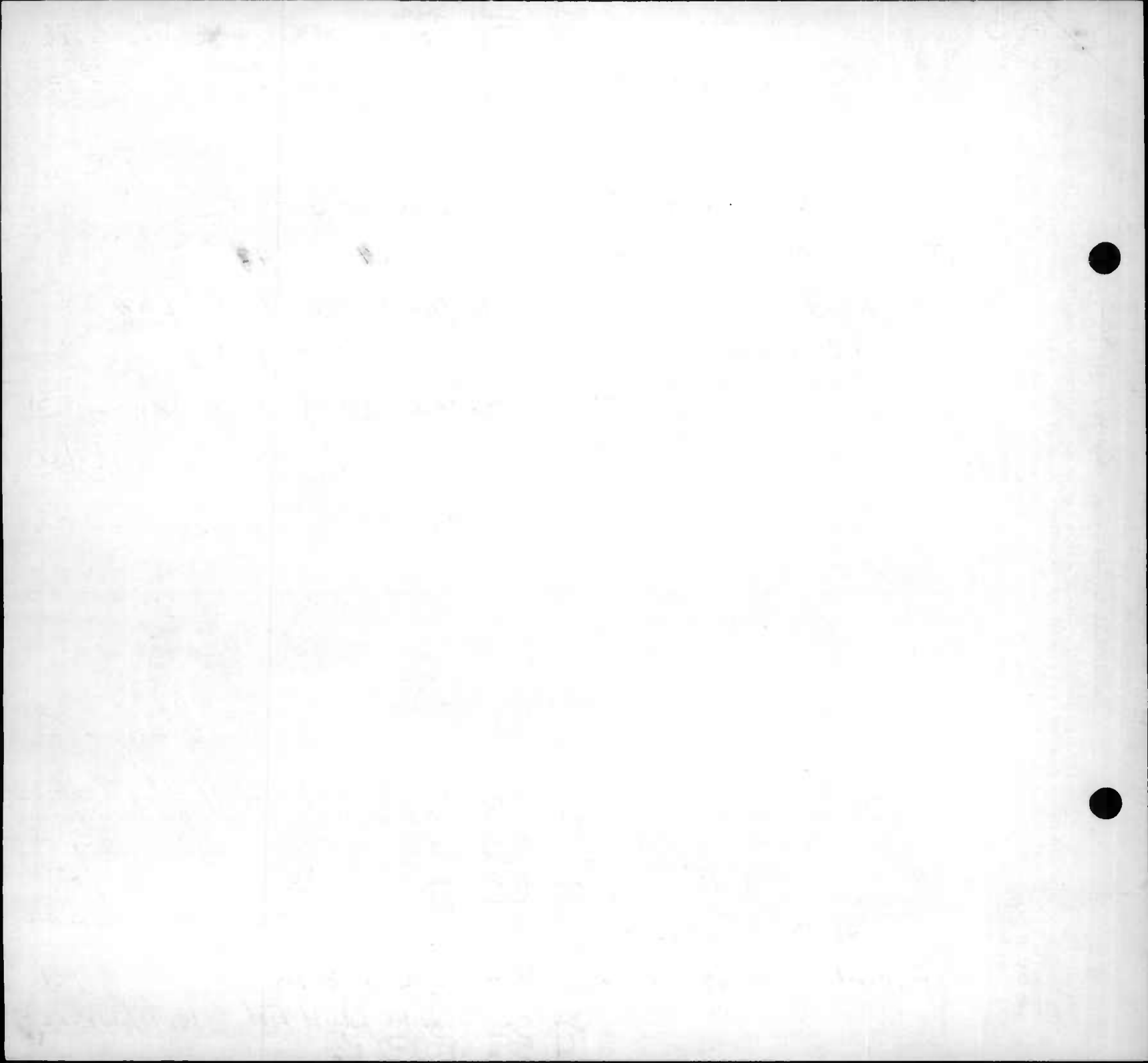
रमेशचंद्र

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | Registered No. |
|---|--------------|--|-------------------------------------|---|--|--|--|--|--|----------------|
| CERTIFICATE OF DEATH | | | | | | | | | | 67 4074 |
| BIRTH NO.
67 4074 | | | | | | | | | | |
| M.E. CASE NO. | | | | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print)
YOUNG, MORTENSE E. | | | | | 2. DATE AND HOUR OF DEATH
4/22/67 9 ⁰⁰ P. M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION
38 UNIVERSITY HOSPITAL
(If not in hospital or institution, give street address or location) | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN BALTO.
(If outside city limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location)
1524 BRUCE ST | | | | | |
| 5. SEX
F | 6. RACE
N | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
S | 8. DATE OF BIRTH
4/28/24 | 9. AGE (In years lost birthday)
43 | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Min. | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Unemployed | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | 11. BIRTHPLACE (State or foreign country)
Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | |
| 13. FATHER'S NAME
ARTHUR YOUNG | | | | | 14. MOTHER'S MAIDEN NAME
BESSIE YOUNG | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO.
15-77-71 | | 17. INFORMANT ADDRESS
Mrs. Bessie Young 700 N. Dennison St. | | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
420.1 I
MYOCARDIAL INFARCTION
1 1/2 Hour | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | ARTHERO SCLEROTIC HEART DISEASE | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No)
Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 4/19 1967 to 4/22 1967, that (I) (we) last saw the deceased alive on 4/22 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | |
| 23A. SIGNATURE
Arnold Schorack | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | 23B. DATE SIGNED
4/22/67 | | |
| 23C. PHYSICIAN'S NAME (Type)
ARNOLD SCHORACK | | | | | 23D. ADDRESS
UNIVERSITY HOSPITAL | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
4-29-67 | | 24C. NAME OF CEMETERY OR CREMATORY
Arbutus Mem. Park | | 24D. LOCATION (City, town, or county) (State)
Arbutus, Md. | | | | |
| 25A. DATE RECD. BY HEALTH DEPT.
APR 25 1967 | | 25B. NAME OF REGISTRAR
Robert E. Taylor | | | 25C. FUNERAL DIRECTOR
Morton & Dyett F.H. | | | ADDRESS
1701 LAURENS ST. | | |



F-422

67 4075

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 4075

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

CHARLES F. FOWLKES

2. DATE AND HOUR PRONOUNCED DEAD

April 21, 1967 7:50 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

University Hospital (DHA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

111 Walnut Ave.

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

WIDOWED

8. DATE OF BIRTH

5-24-1898

9. AGE (In years
last birthday)

68

If Under 1 Yr. If Under 24 Hrs.
Months, Days, Hours, Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

RETIRED

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

CREWE, VIRGINIA

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

JAMES HODGE FOWLKES

14. MOTHER'S MAIDEN NAME

ROSE FOWLKES

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mr. Hodge Dyson 1619 Moreland Avenue

18. 420.0

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic heart disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
WORKNOT WHILE
AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4-22-67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

4-24-67

23C. NAME OF CEMETERY or CREMATORY

Jackson Cemetery

23D. LOCATION

Crewe,

(City, town, or county)

(State)

Va.

24A. DATE REC'D BY HEALTH DEPT.

APR 25 1967

24B. NAME OF REGISTRAR

Robert E. Johnson

24C. FUNERAL DIRECTOR

MORTON & DYETT F.H. 1701 Laurens

ADDRESS

VALLEY MAPER
WILLIAMS & BROTHERS

This certificate must be approved by the Medical Director of the hospital or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 67 4076 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 97-92-36 | |
|---|---------------------|---|--------------------------------------|---|----------------------------|--|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) <i>Ware Yannak</i> | | | | 2. DATE AND HOUR OF DEATH
<i>4/24/67 5:50 P.M.</i> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<i>33 THE JOHNS HOPKINS HOSPITAL</i> | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE <i>Maryland</i>
B. COUNTY <i>Baltimore</i>
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>10-01</i>
D. STREET ADDRESS (If rural, give location) <i>1032 N. WARREN Street</i> | | | |
| 5. SEX
<i>F</i> | 6. RACE
<i>C</i> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<i>Widowed</i> | 8. DATE OF BIRTH
<i>7-10-1899</i> | 9. AGE (In years lost birthday)
<i>68</i> | If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<i>Alabama</i> | | 12. CITIZEN OF WHAT COUNTRY?
<i>U.S.</i> | |
| 13. FATHER'S NAME
<i>JAMES MOSES</i> | | | | 14. MOTHER'S MAIDEN NAME
<i>NANCY CARTER</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
<i>570.517260X</i>
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>diabetes mellitus</i> | | | | CAUSE OF DEATH
(A) <i>respiratory arrest</i>
DUE TO
(B) <i>aspiration of undigested contents</i>
DUE TO
(C) <i>intestinal obstruction 24 hrs</i> | | INTERVAL BETWEEN ONSET AND DEATH
<i>24 hrs</i> | |
| 19A. DATE OF OPERATION
<i>none</i> | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<i>No</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>4-24-1967</i> to <i>4-24-1967</i> , that (I) (we) last saw the deceased alive on <i>4-24-1967</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
<i>James L Phillips</i> M.D. | | | | 23B. DATE SIGNED
<i>4-24-67</i> | | 23C. PHYSICIAN'S NAME (Type)
<i>JAMES L PHILLIPS</i> M.D. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | | | | 24B. DATE
<i>4-28-67</i> | | 24C. NAME OF CEMETERY OR CREMATORY
<i>Carver Memorial</i> | |
| 24D. LOCATION (City, town, or county) (State)
<i>laurel Md.</i> | | | | 25A. DATE REC'D BY HEALTH DEPT.
<i>APR 26 1967</i> | | | |
| 25B. NAME OF REGISTRAR
<i>Robert E. Taylor</i> | | | | 25C. FUNERAL DIRECTOR ADDRESS
<i>C. Wainwright 2706 Edmondson Ave</i> | | | |

7-15-1889 CR

Chickens

4-8

Y

BW-181 4-28-85 (GIVEN MEMPHIS 1946) 179.

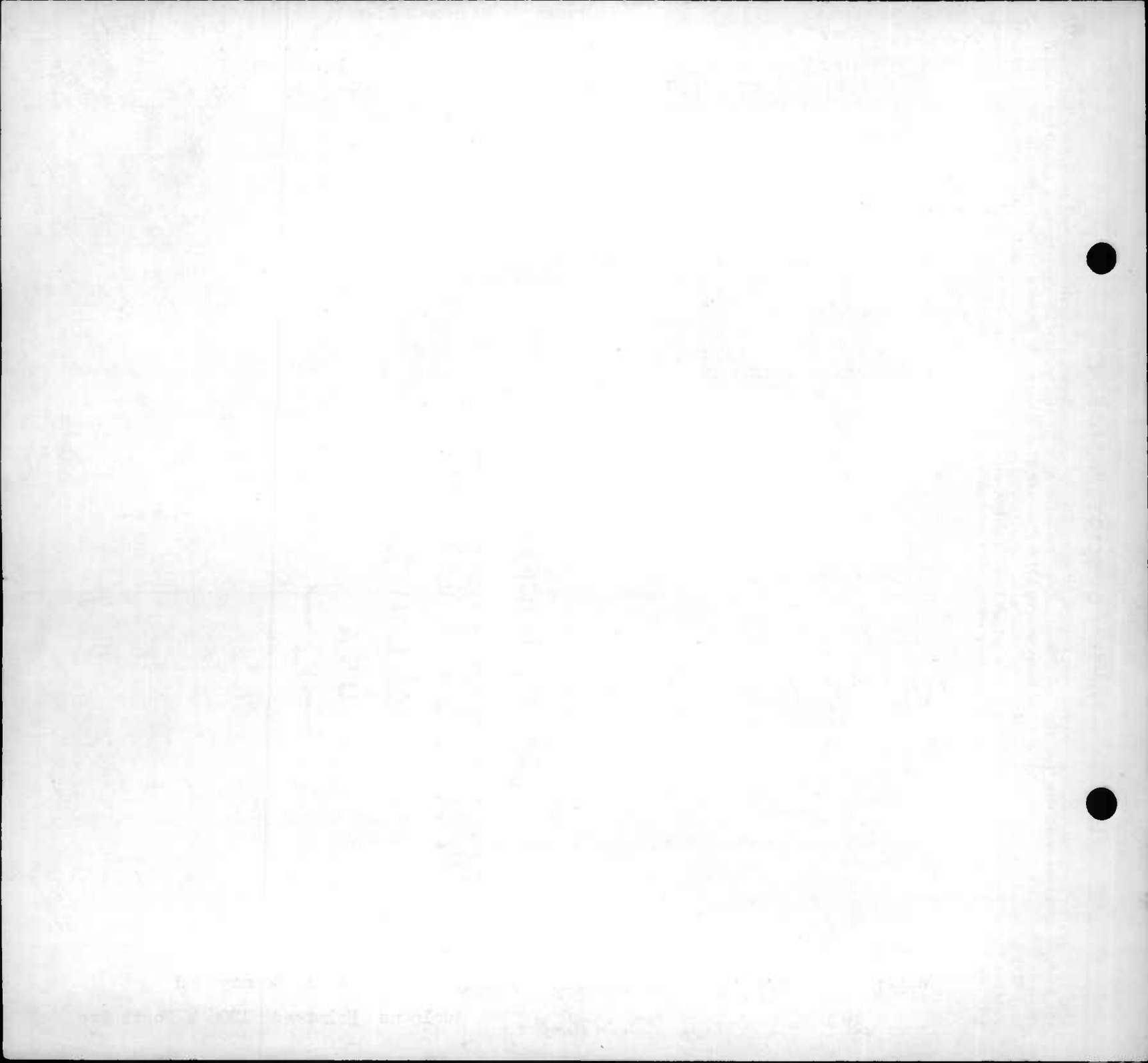
2nd Generation

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REGISTERED No. 678 4077 | |
|---|--|--|--|--|--|
| CERTIFICATE OF DEATH | | | | SSPS | |
| BIRTH NO. 1379 4077 | | M.E. CASE NO. | | DR. JAMES B. 678 4077 | |
| 1. NAME OF DECEASED
(Type or Print) GRIMES, Pete Paul | | 2. DATE AND HOUR OF DEATH
April 23, 1967 5:15 A.M. | | DR. JAMES B. 678 4077 | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
38 University Hospital | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE MD
B. COUNTY | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore 17-01 | |
| 5. SEX M | | 6. RACE C | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
separated | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Radio Repair | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Georgia | |
| 13. FATHER'S NAME
William Grimes | | 14. MOTHER'S MAIDEN NAME
MARY | | 12. CITIZEN OF WHAT COUNTRY?
U.S. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Medical Record | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
930 XI
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) Rupture of cerebral aneurysm
(B) Hypertension, Essential
(C) | | INTERVAL BETWEEN ONSET AND DEATH
4/20/67 ↔ 4/23/67
? | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
April 18, 1967 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
Tumor | | 20A. AUTOPSY? (Yes or No)
No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from April 4, 1967 to April 23, 1967, that (I) (we) lost saw the deceased alive on April 23, 1967 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Youngsik Moon | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
April 23, 1967 | |
| 23C. PHYSICIAN'S NAME (Type)
Youngsik Moon | | 23D. ADDRESS
M.D. University Hospital, Baltimore, MD | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
4/30/67 | | 24C. NAME OF CEMETERY or CREMATORY
Mt. Calvary Cemetery | |
| 24D. LOCATION
A A County Md | | 25A. DATE REC'D BY HEALTH DEPT.
APR 26 1967 | | | |
| 25B. NAME OF REGISTRAR
Robert E. Jackson | | 25C. FUNERAL DIRECTOR
Adolphus Halstead 1206 W North Ave | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 4078 | |
|--|---------------------|---|------------------------------|---|---|
| BIRTH NO. 67 4078 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) Laura Jackson | | 2. DATE AND HOUR OF DEATH
April 22, 1967 | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION

1636 Thomas Ave | | A. STATE Md
B. COUNTY

C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
1636 Thomas Ave | | | |
| 5. SEX
F | 6. RACE
C | 7. MARRIED, NEVER MARRIED
WIDOWED | 8. DATE OF BIRTH
? | 9. AGE
lost 65 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 13. FATHER'S NAME
Adolphus | | 14. MOTHER'S MAIDEN NAME
? | | 12. CITIZEN OF WHAT COUNTRY?
U S A | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
Mr Chesly same | |
| 18. 420.11-481X
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) Coronary occlusion
DUE TO
(B) Hypertensive C.V. Disease
DUE TO
(C) Arteriosclerosis | | INTERVAL BETWEEN ONSET AND DEATH
24-36 h.

unknown

unknown | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | Emphysema | | 2 wk | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Nov 1962 to Apr 17 1967 , that (I) was lost saw the deceased alive on Apr 17 1967 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) was did (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
H. Garland Chissell | | | | 23B. DATE SIGNED
4-25-67 | |
| 23C. PHYSICIAN'S NAME (Type)
H. Garland Chissell | | | | 23D. ADDRESS
1038 Edmondson Ave Baltimore Md | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
4/27/67 | | 24C. NAME OF CEMETERY or CREMATORY
Mt Calvary Cemetry | |
| 24D. LOCATION (City, town, or county) (State)
A A County M; | | 25A. DATE REC'D BY HEALTH DEPT.
APR 26 1967 | | | |
| 25B. NAME OF REGISTRAR
Robert E. Taylor | | 25C. FUNERAL DIRECTOR ADDRESS
Adolphus Halstead 1206 W North Ave | | | |

1000 1000

1000 1000

1000 1000

1000 1000

1000 1000

1000 1000

1000 1000

1000 1000

1000 1000

1000 1000

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|---------|--|--|--|------------------|--|---------------------------------|--|--|--|-----------------------------|--|--|--|--|--|--|--|----------------------------------|--|--|--|--|
| 67 4079 | | | | | CERTIFICATE OF DEATH | | | | | Registered No. 67 4079 | | | | | | | | | | | | | | |
| BIRTH NO. | | | | | M.E. CASE NO. | | | | | 1. NAME OF DECEASED
(Type or Print) | | | | | 2. DATE AND HOUR OF DEATH | | | | | | | | | |
| | | | | | PARTHENIA BUNCH | | | | | 4-23-67 | | | | | 8:30 P.M. | | | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | | | | | | | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location) | | | | | | | | | | A. STATE
B. COUNTY | | | | | | | | | | | | | | |
| 33 THE JOHNS HOPKINS HOSPITAL | | | | | | | | | | MARYLAND | | | | | | | | | | | | | | |
| | | | | | | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE | | | | | | | | | | | | | | |
| | | | | | | | | | | D. STREET ADDRESS (If rural, give location)
2503 E. FEDERAL ST. | | | | | | | | | | | | | | |
| 5. SEX | | 6. RACE | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH | | 9. AGE (In years lost birthday) | | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | | | | | | | | | | | |
| FEMALE | | NEGROID | | MARRIED | | 11-24-08 | | 56 58 | | | | | | | | | | | | | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | | | 11. BIRTHPLACE (State or foreign country) | | | | | 12. CITIZEN OF WHAT COUNTRY? | | | | | | | | | |
| Domestic | | | | | Public | | | | | Akoskie, N.C. | | | | | U.S.A. | | | | | | | | | |
| 13. FATHER'S NAME | | | | | 14. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | | | | | |
| HENRY PEELE | | | | | SUSAN MANLEY | | | | | | | | | | | | | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | | 16. SOCIAL SECURITY NO. | | | | | 17. INFORMANT | | | | | ADDRESS | | | | | | | | | |
| NO | | | | | 218-36-9659 | | | | | James H. Peele | | | | | 2505 E. Oliver St. | | | | | | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | | | | | | | CAUSE OF DEATH | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | | | | | | | (A) DUE TO | | | | | | | | | | CHF. | | | | |
| ANTECEDENT CAUSES | | | | | | | | | | (B) DUE TO | | | | | | | | | | Hypertension | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | | | | (C) | | | | | | | | | | | | | | |
| II | | | | | | | | | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | Uremia, renal failure | | | | |
| 19A. DATE OF OPERATION | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20A. AUTOPSY? (Yes or No) | | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | |
| | | | | | | | | | | NO | | | | | NO | | | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | | | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | | 21E. INJURY OCCURRED | | | | | 21F. HOW DID INJURY OCCUR? | | | | | | | | | | | | | | |
| | | | | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | |
| 22. I certify that (1) (this hospital) attended the deceased from 4/11/67 to 4/23/67, that (1) (we) last saw the deceased alive on 8:30 PM 4/23/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | |
| 23A. SIGNATURE | | | | | | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | | 23B. DATE SIGNED | | | | | | | | | |
| Tah-Hsiung Hsu | | | | | | | | | | | | | | | 4/23/67 | | | | | | | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | | | | | | | 23D. ADDRESS | | | | | | | | | | | | | | |
| Tah-Hsiung Hsu | | | | | | | | | | The Johns Hopkins Hospital | | | | | | | | | | | | | | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) | | | | | 24B. DATE | | | | | 24C. NAME OF CEMETERY OR CREMATORY | | | | | 24D. LOCATION (City, town, or county) (State) | | | | | | | | | |
| Removal | | | | | 4-25-67 | | | | | Baptist Cr. & Y. | | | | | Akoskie, N.C. | | | | | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | | | | 25B. NAME OF REGISTRAR | | | | | 25C. FUNERAL DIRECTOR | | | | | ADDRESS | | | | | | | | | |
| APR 26 1967 | | | | | R. J. 2. Talone | | | | | Randolph J. Collick | | | | | 2431 E. Oliver St. | | | | | | | | | |

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 4080 | |
|--|-----------------------------|---|-------------------------------------|---|---|
| BIRTH NO. 67 4080 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) DUNNOCK, JOSEPH F | | | |
| 2. DATE AND HOUR OF DEATH
APRIL 25, 1967 1:10AM M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

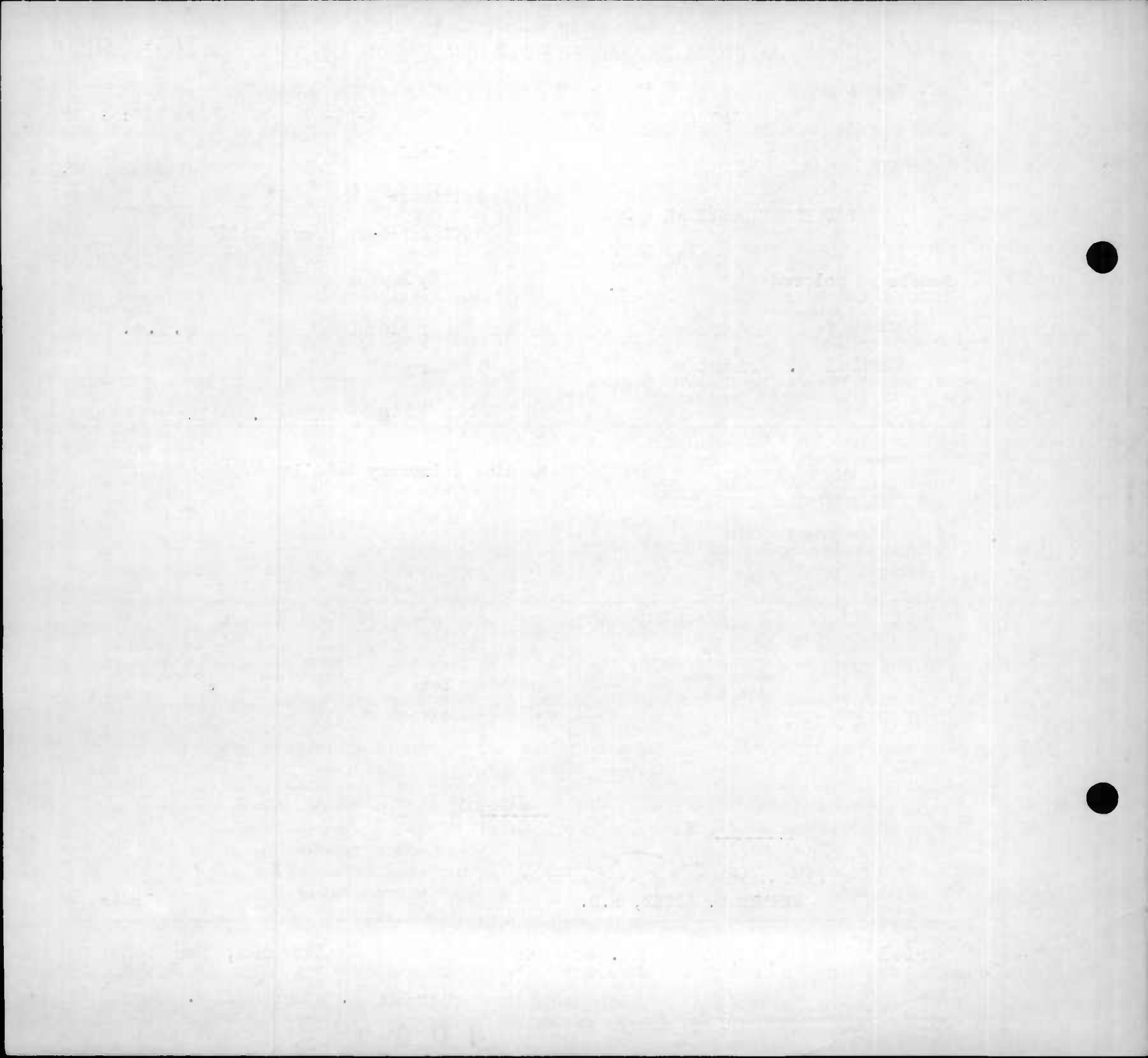
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
40 ST. AGNES HOSPITAL WILKENS & CATON AVES. BALTIMORE 29, MD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD.
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE
D. STREET ADDRESS (If rural, give location)
116 S. GILMOR ST. | | | |
| 5. SEX
MALE | 6. RACE
CAUCASION | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
SINGLE | 8. DATE OF BIRTH
04-05-94 | 9. AGE (In years last birthday)
73 | 10. AGE (In years last birthday)
73 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
RETIRED- | | 10B. KIND OF BUSINESS OR INDUSTRY
CITY | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | |
| 13. FATHER'S NAME
JOSEPH DUNNOCK | | 14. MOTHER'S MAIDEN NAME
DEC'D MARGARET SHENTON | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | |
| 16. SOCIAL SECURITY NO.
217-09-7571 | | 17. INFORMANT ADDRESS
ST. AGNES RECORDS: WILKENS & CATON AVES | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
Recent myocardial infarction | | CAUSE OF DEATH
(A) DUE TO
Pericardial disease, drained
(B) DUE TO
Staphylococcal infection of kidney
(C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> Yes | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from MARCH 11, 1967 to APRIL 25, 1967 , that (I) (we) last saw the deceased alive on APRIL 25, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Walter G. Rudin M.D. | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
4-28-67 | |
| 23C. PHYSICIAN'S NAME (Type)
Walter G. Rudin | | 23D. ADDRESS
St Agnes Hospital Baltimore Md | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
4-28-67 | | 24C. NAME of CEMETERY or CREMATORY
St Marys Star Sea Ch Cemetery | |
| 24D. LOCATION (City, town, or county) (State)
Golden Hill, Church Creek Md | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 26 1967 | | 25B. NAME OF REGISTRAR
Robert E. Taylor | | 25C. FUNERAL DIRECTOR
Thomas J. Kenny Inc 1600 Hollins St | |

1
T-460

BIRTH NO. 67 4081
MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 4081

| | | | |
|---|---------------------------|---|--|
| 1. NAME OF DECEASED
(Type or Print)
EIMIRA TAYLOR | | 2. DATE AND HOUR PRONOUNCED DEAD
4-24-67 12:59 PM | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
PROVIDENT HOSPITAL - DOA | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY X
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
1601 Bakebury Court 21217 | |
| 5. SEX
Female | 6. RACE
Colored | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
W. | 8. DATE OF BIRTH
4/16/88 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | 9. AGE (In years last birthday)
79 |
| 13. FATHER'S NAME
Daniel R. Wright | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 14. MOTHER'S MAIDEN NAME
Mary |
| 17. INFORMANT ADDRESS
Otis Sliney 1119 W. Mulberry St | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 18. CAUSE OF DEATH
I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
Massive pulmonary embolism
(A) DUE TO
II
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) DUE TO
(C) DUE TO
III
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION
2 | | 20A. AUTOPSY? (Yes or No)
Yes | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
Yes | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (m.) | | 21E. HOW DID INJURY OCCUR? | |
| 21F. HOW DID INJURY OCCUR?
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | |
| 23A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 23B. DATE
4/28/67 | |
| 23C. NAME of CEMETERY or CREMATORY
Mt. Auburn | | 23D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | |
| 24A. DATE REC'D BY HEALTH DEPT.
APR 26 1967 | | 24B. NAME OF REGISTRAR
Charles A. Rice | |
| 24C. FUNERAL DIRECTOR ADDRESS
Charles A. Rice 661 W. Barre St | | 24D. NAME OF EXAMINER
Werner U. Spitz, M.D. | |

APR 26 1967 4081



C-415-1
Released by M.E.O.
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

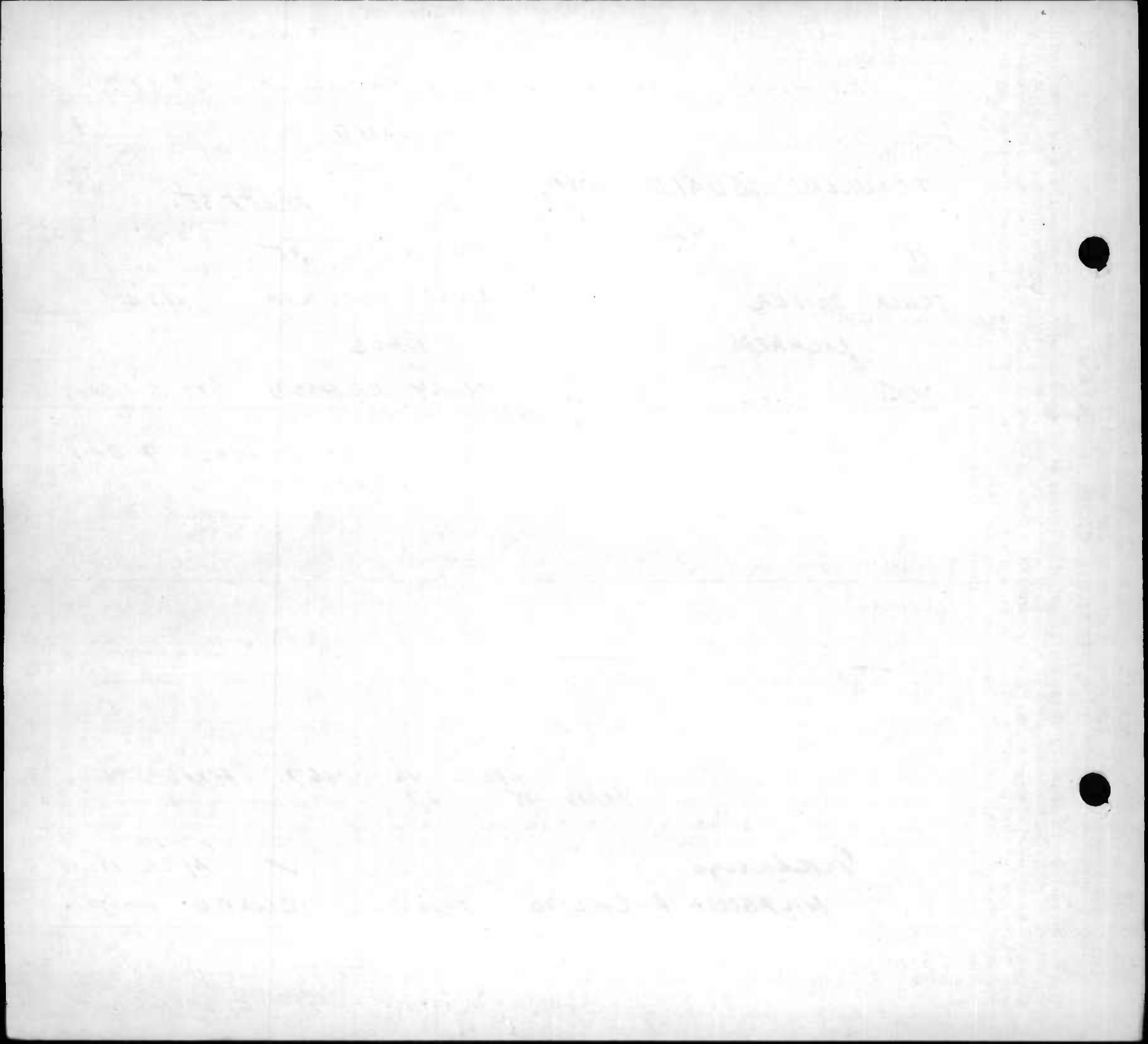
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 4082 | |
|--|--------------|--|----------------------------|--|--|
| 67 4082 | | | | 67 4082 | |
| CERTIFICATE OF DEATH | | | | M. E. CASE NO. | |
| 1. NAME OF DECEASED
(Type or Print) COLVIN, ROBERT, SR. | | 2. DATE AND HOUR OF DEATH
4/23/67 11:30 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
38 UNIVERSITY HOSPITAL | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE Md.
B. COUNTY BALTIMORE
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE
D. STREET ADDRESS (If rural, give location)
837 S PACA ST | | | |
| 5. SEX
M | 6. RACE
C | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH
4/2/10 | 9. AGE (In years
last birthday)
56 | 10. If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
UNKNOWN | |
| 13. FATHER'S NAME
UNKNOWN | | 14. MOTHER'S MAIDEN NAME
UNKNOWN | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Robert Colvin Jr. 841 W. Ostenda. | |
| 18. 1971-3 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) SQUAMOUS CELL CARCINOMA
(2) MAXILLA
(B) DUE TO
(C) | | INTERVAL BETWEEN ONSET AND DEATH
TYR | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan 23 1969 to — 19 —, that (I) (we) last saw the deceased alive on March 28 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Kurt P. Sligar | | | | 23B. DATE SIGNED
4/23/67 | |
| 23C. PHYSICIAN'S NAME (Type)
KURT P. SLIGAR | | | | 23D. ADDRESS
UNIVERSITY HOSPITAL | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
4/27/67 | | 24C. NAME OF CEMETERY or CREMATORY
Mt Auburn | |
| 24D. LOCATION (City, town, or county) (State)
Baltimore, Md | | 25A. DATE REC'D BY HEALTH DEPT.
APR 26 1967 | | | |
| 25B. NAME OF REGISTRAR
R. E. Taylor | | 25C. FUNERAL DIRECTOR
Charles A. Rice 661 W. Barr | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | Registered No. 67 4083 | |
|--|---------------------|---|--|--|---|--|--|--|--|---|--|
| BIRTH NO. 67 4083 | | | | | | | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | | | | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) RICHARDS, CALVIN JACKSON | | | | | 2. DATE AND HOUR OF DEATH
APRIL 25, 1967 7:20 A.M. | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE MARYLAND
B. COUNTY BALTIMORE
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE
D. STREET ADDRESS (If rural, give location)
1132 W. PRATT ST. | | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
FRANKLIN SQUARE HOSP. | | | | | | | | | | | |
| 5. SEX
M | 6. RACE
W | 7. <input checked="" type="checkbox"/> MARRIED NEVER MARRIED
WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH 23 MARCH 1932 | | 9. AGE (In years last birthday)
35 | | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
TRUCK DRIVER | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | | 11. BIRTHPLACE (State or foreign country)
WEST VIRGINIA | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
RICHARDS | | | | | 14. MOTHER'S MAIDEN NAME
ROSA BALL | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
YES KOREA | | | | 16. SOCIAL SECURITY NO.
236-48-8163 | | 17. INFORMANT ADDRESS
MARY RICHARDS 1132 W PRATT ST. | | | | | |
| 18. 420.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ACUTE MYO CARDIAL INFARCTION
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
9 DAYS | |
| MEDICAL CERTIFICATION | | | | | | | | | | | |
| 19A. DATE OF OPERATION
0 | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from APRIL 16 1967 to APRIL 25 1967 , that (I) (we) last saw the deceased alive on APRIL 25 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE
Milagro R. Calizo | | | | | | | | | | 23B. DATE SIGNED
APRIL 25, 1967 | |
| 23C. PHYSICIAN'S NAME (Type)
MILAGROSA R. CALIZO M.D. | | | | | | | | | | 23D. ADDRESS
FRANKLIN SQUARE HOSP. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | | | 24B. DATE
4/29/67 | | 24C. NAME OF CEMETERY or CREMATORY
Richards | | | | 24D. LOCATION (City, town, or county) (State)
Sophia W. VA. | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 20 1967 | | | | 25B. NAME OF REGISTRAR
Robert E. Salzman | | | | 25C. FUNERAL DIRECTOR ADDRESS
Witzke 4101 Edmondson Ave | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 4084 | |
|---|---------------------|---|-----------------------------------|---|--|
| BIRTH NO. 67 4084 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) Mrs. Allison Zies. | | 2. DATE AND HOUR OF DEATH
April 24 1967 10:30 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
44 Union Memorial Hospital Balto., Md. | | A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 500 W. University Pkwy. | | | |
| 5. SEX
F | 6. RACE
W | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widowed | 8. DATE OF BIRTH
4-2-82 | 9. AGE (In years last birthday)
85 | 10. CITIZEN OF WHAT COUNTRY?
USA |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
New Jersey | |
| 13. FATHER'S NAME
John Warren | | 14. MOTHER'S MAIDEN NAME
Ella Nicklas | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Mrs. Florence Noll
500 University Pkwy. - 21210 | |
| 18. 451X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. If means the disease, injury or complication which caused death.)
abdominal Aortic Aneurysm | | CAUSE OF DEATH
(A) Rupture of Thoraco-
DUE TO
(B) abdominal Aortic Aneurysm
DUE TO
(C) | | INTERVAL BETWEEN ONSET AND DEATH | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No. | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from February 19 67 to April 19 67 , that (I) was lost saw the deceased alive on April 22 19 67 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) was (did) did not view the body after death. | | | | | |
| 23A. SIGNATURE
Lester A. Wall, Jr. | | | | 23B. DATE SIGNED
April 24 1967 | |
| 23C. PHYSICIAN'S NAME (Type)
Lester A. Wall, Jr. | | 23D. ADDRESS
1039 S.T. Paul St. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Entombment | | 24B. DATE
4-27-67 | | 24C. NAME OF CEMETERY or CREMATORY
Lorraine Pk. Mausoleum | |
| 24D. LOCATION (City, town, or county) (State)
Baltimore, Md. | | 25A. DATE REC'D BY HEALTH DEPT.
6 1967 | | | |
| 25B. NAME OF REGISTRAR
Robert E. Taylor | | 25C. FUNERAL DIRECTOR
Witzke F. D. - 4101 Edmondson Ave. | | | |

John W. Miller, Jr.
1910

1910

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1910

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1910

1910

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|---|--|--|--|--|---|--|--|------------------------------|
| CERTIFICATE OF DEATH | | | | | Registered No. 67 4085 | | | | |
| BIRTH NO. 67 4085 | | | | | M.E. CASE NO. | | | | |
| 1. NAME OF DECEASED
(Type or Print) ELLA ROBINSON | | | | | 2. DATE AND HOUR OF DEATH
4/22/67 9:15 A.M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

Bolton Hill Nursing Center
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
90 | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Howard Co
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Ellicott City 63-00
D. STREET ADDRESS (If rural, give location)
14 St. Paul Street | | | | |
| 5. SEX
Female | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widowed | 8. DATE OF BIRTH
4-17-1884 | 9. AGE (In years last birthday)
83 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME
Evan Day | | | 14. MOTHER'S MAIDEN NAME
Clara Bell Pool | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | |
| 16. SOCIAL SECURITY NO.
212-30-3508 | | | 17. INFORMANT
Bolton Hill Records | | | | ADDRESS | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH
CARCINOMA OF CERVIX
(A) DUE TO

(B) DUE TO

(C) DUE TO

INTERVAL BETWEEN ONSET AND DEATH | | | | | 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1/19/66 19 to 4/22/67 19, that (I) (we) last saw the deceased alive on 4/22/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (do) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
[Signature] M.D. | | | | | 23B. DATE SIGNED
4/22/67 | | | 23C. PHYSICIAN'S NAME (Type)
Harris Tennant M.D. | |
| 23D. ADDRESS
5514 Kenwood Ave Baltimore, Md. | | | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
4-25-1967 | | 24C. NAME OF CEMETERY or CREMATORY
Good Shepherd | | 24D. LOCATION (City, town, or county) (State)
Ellicott City, Md | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR
F.C. Higginbotham | | ADDRESS
Ellicott City, Md. | | | |

1911

1/20/11

Received

from

James A. Green

1/20/11

1/20/11

James A. Green

James A. Green

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | Registered No. 67 4086 | |
|---|--------------|---|---|---|---|--|--|------------------------------|---------|----------------------------------|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| BIRTH NO. 67 4086 | | | | | | | | | | | |
| M.E. CASE NO. | | | | | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) KATHERINE M. MYERS | | | | | 2. DATE AND HOUR OF DEATH
4-24-1967 2 P.M. | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE Md B. COUNTY Balto Co. | | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
MONTABELLO HOSP. BALT. MD | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE CO 53-00 | | | | | | |
| D. STREET ADDRESS (If rural, give location)
4016 VILLA NOVA | | | | | | | | | | | |
| 5. SEX
Female | 6. RACE
W | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
married | | 8. DATE OF BIRTH
6-10-1909 | 9. AGE (In years lost birthday)
57 | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Min. | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
house wife | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Md. | | 12. CITIZEN OF WHAT COUNTRY? | | | |
| 13. FATHER'S NAME
HARVEY MERSON | | | | | 14. MOTHER'S MAIDEN NAME
Cook | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No. | | | | 16. SOCIAL SECURITY NO.
220-093917 | | 17. INFORMANT
John V MYERS 690 WASHINGTON BLVD | | | ADDRESS | | |
| 18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
metastatic ca of the Breast Rt. to lungs | | | | | CAUSE OF DEATH
(A) DUE TO
(B) DUE TO
(C) | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No)
No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 7-12-1967 to 4-24-1967, that (I) (we) last saw the deceased alive on 4-24-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE
Young Hea Lew | | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Stof Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
4-24-67 | | | | |
| 23C. PHYSICIAN'S NAME (Type)
YOUNG HEA LEW | | | | | 23D. ADDRESS
Montabello State Hosp | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
4/27-67 | | 24C. NAME of CEMETERY or CREMATORY
LORRAINE PK | | 24D. LOCATION (City, town, or county) (State)
BALTIMORE city Md | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 26 1967 | | | 25B. NAME OF REGISTRAR
Robert E. Taylor | | | 25C. FUNERAL DIRECTOR
Frank M. Leach 814 W 36th St. | | | ADDRESS | | |

BIRTH NO. 67 4087 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 4087

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

LEE Morgan JONES, Jr.

2. DATE AND HOUR PRONOUNCED DEAD

April 21, 1967 7:45 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

38 University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland B. COUNTY Dorchester Co.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Cambridge

D. STREET ADDRESS (If rural, give location)

Route # 1

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Never married

8. DATE OF BIRTH

Sept. 24, 1946

9. AGE (In years
last birthday)

20

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Electricians helper

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Cambridge

12. CITIZEN OF
WHAT COUNTRY?

U.S.

13. FATHER'S NAME

Lee Morgan Jones, Sr.

14. MOTHER'S MAIDEN NAME

Mitty Gillis

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

217-44-1926

17. INFORMANT

Lee M. Jones, Sr., Cambridge, Md., R.D. 1

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

Gunshot wound of head

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION

WAS PERFORMED
Gunshot wound

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRI-
BUTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Yard at home

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Route #1, Cambridge, Md.

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
4-18-67 11:00 A.

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Shot self

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4-22-67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

Apr. 23, 1967

23C. NAME OF CEMETERY or CREMATORY

Jones Family Cemetery

23D. LOCATION

(City, town, or county)

Cambridge, Md., R.D.

(State)

24A. DATE REC'D BY HEALTH DEPT.

APR 26 1967

24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

Samuel P. Thomas

ADDRESS

Cambridge, Md.

WALL PAPER

WALL PAPER

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | |
|--|-----------|---|--|--|--|--|---|--|--|--|
| CERTIFICATE OF DEATH | | | | | Registered No. 67 4088 | | | | | |
| BIRTH NO. 67 4088 | | M.E. CASE NO. | | | 1. NAME OF DECEASED (Type or Print) THAL, FREDERICK J. | | | 2. DATE AND HOUR OF DEATH 4-22-67 6 45 P.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Balto Co. | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) North Charles General Hosp. | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 6 53-00 | | | | | |
| D. STREET ADDRESS (If rural, give location) 8317 Philadelphia Rd. | | | | | | | | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | | | 8. DATE OF BIRTH 12-25-90 | 9. AGE (In years last birthday) 76 | 10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min. | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Motorman | | | 10B. KIND OF BUSINESS OR INDUSTRY Baltimore Transit | | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13. FATHER'S NAME Stephen Thal | | | | | 14. MOTHER'S MAIDEN NAME Elizabeth Flavaus | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWI | | | 16. SOCIAL SECURITY NO. 213 10 2687 | | 17. INFORMANT ADDRESS Esther M. Jacob 8317 Philadelphia Rd. | | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | | | | CAUSE OF DEATH | | | | | |
| ANTECEDENT CAUSES | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | (A) Acute Myocardial Infarction 48 hrs ± | | | | | |
| | | | | | (B) Coronary Thrombosis 48 hrs ± | | | | | |
| | | | | | (C) Arteriosclerotic Hypertensive 2 yrs ± Cardiovascular Disease | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | Uremia, Ca of the Colon + Prostate | | | | | |
| 19A. DATE OF OPERATION 2 | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (A) (this hospital) attended the deceased from 4-21 1967 to 4-22 1967, that (A) (we) last saw the deceased alive on 4-22 1967 and that in (A) (our) opinion death occurred on the date and hour and from the causes stated above. (A) (We) (did) (did not) view the body after death. | | | | | | | | | | |
| 23A. SIGNATURE R. J. DUREZA | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input checked="" type="checkbox"/> | | | 23B. DATE SIGNED 4-22-67 | | |
| 23C. PHYSICIAN'S NAME (Type) R. J. DUREZA | | | | | 23D. ADDRESS M.D. 2413 A Calburn Ave. Balto. Md 21215. | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | 24B. DATE April 26 1967 | | | 24C. NAME OF CEMETERY OR CREMATORY Emmanuel Luth. Cemetery | | | | |
| 24D. LOCATION (City, town, or county) Baltimore, Maryland. | | | 24E. STATE (State) Maryland. | | | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. APR 26 1967 | | | 25B. NAME OF REGISTRAR Philip E. Talbot | | | 25C. FUNERAL DIRECTOR Coach Funeral Home | | | | |
| | | | | | | ADDRESS 1211 Chiswick Ave. | | | | |

10-22-67

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10-22-67

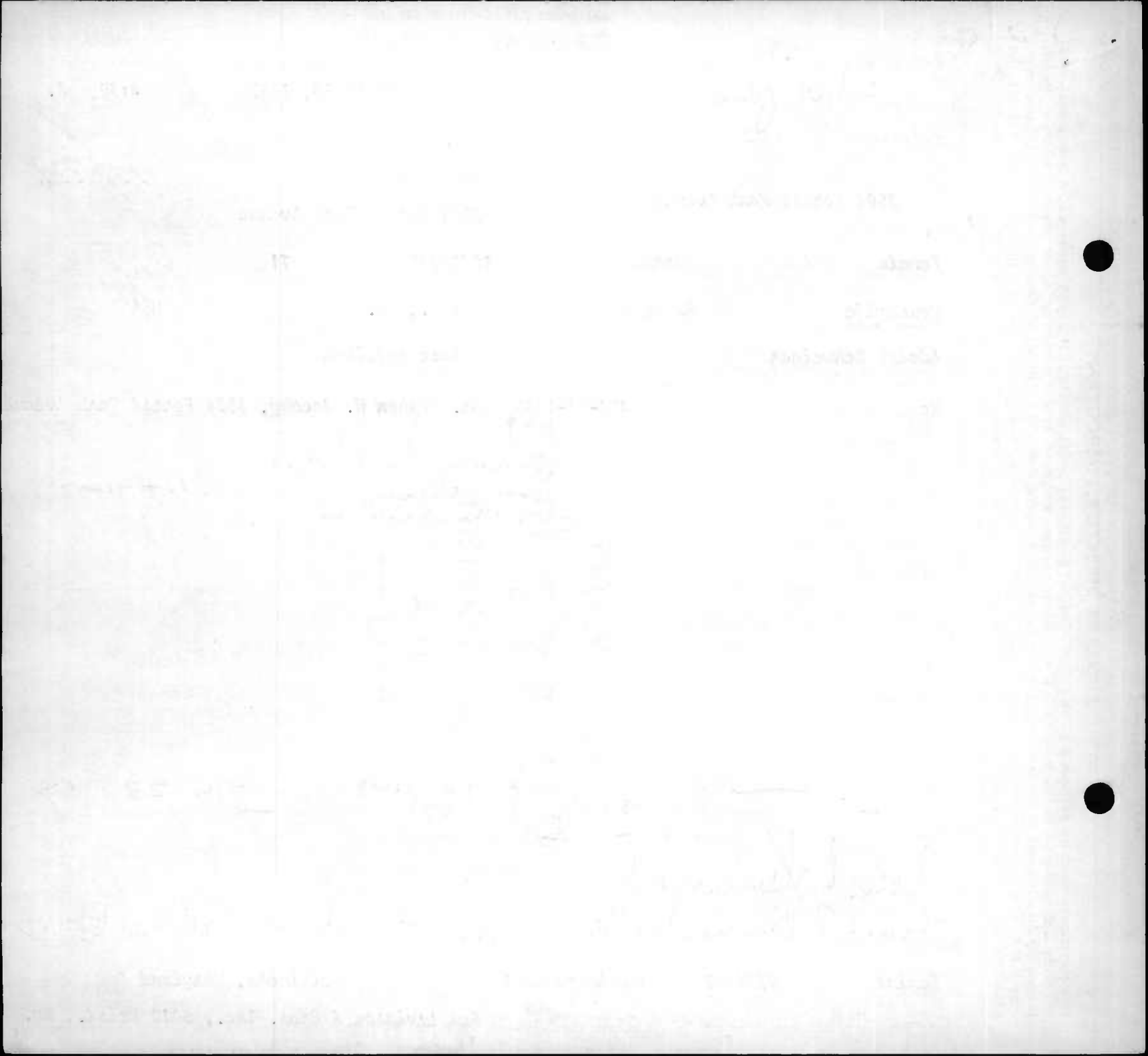
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. **67 4089**

| | | | |
|--|----------------------|--|--|
| BIRTH NO. 67 4089 | | M.E. CASE NO. 4089 | |
| 1. NAME OF DECEASED
(Type or Print) Estelle Jacoby | | 2. DATE AND HOUR OF DEATH
APRIL 23, 1967 8:30 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
3508 Forest Park Avenue | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE Maryland
B. COUNTY Baltimore
C. CITY OR TOWN (If outside city limits, write RURAL and give township) 15-38
D. STREET ADDRESS (If rural, give location)
3508 Forest Park Avenue | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 12/20/95 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY At Home | 9. AGE (In years last birthday) 71 |
| 11. BIRTHPLACE (State or foreign country) Phila., Pa. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Adolph Schweiger | | 14. MOTHER'S MAIDEN NAME Rose Apfelbaum | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 424-09-1435 | 17. INFORMANT ADDRESS Mr. Nathan H. Jacoby, 3508 Forest Park Avenue |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
Coronary Thrombosis
Hypertension
Arteriosclerosis | | INTERVAL BETWEEN ONSET AND DEATH
10+ years | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from for 20 years 19 Apr 23 1967, that (I) (we) lost saw the deceased alive on 21 Apr 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE Chris P. Kamberger Jr. | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type) Louis P. Kamberger Jr. | | 23D. ADDRESS 1001 St Paul St - Baltimore Md 21202 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 4/24/67 | |
| 24C. NAME OF CEMETERY OR CREMATORY Baltimore Hebrew | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. APR 26 1967 | | 25B. NAME OF REGISTRAR Robert E. Fisher, M.D. | |
| 25C. FUNERAL DIRECTOR Sol Levinson & Bros. Inc., 6010 Reist., Rd. | | 25D. ADDRESS | |

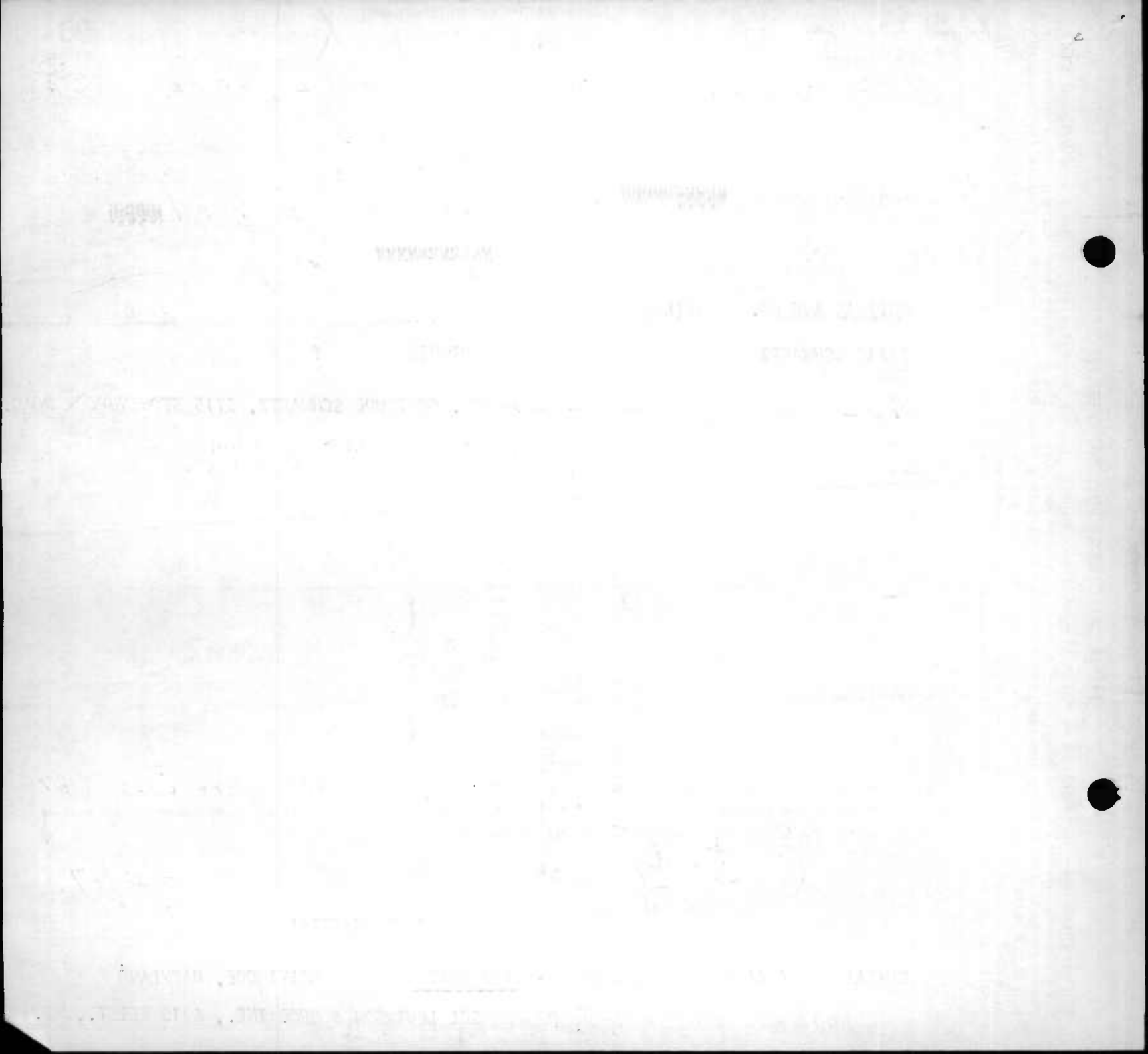


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 67 4090 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 4090 | |
|---|---------------------|--|---------------------------------------|---|---|---|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) SCHWARTZ, HYMAN | | | | 2. DATE AND HOUR OF DEATH
APRIL 23, 1967 12⁵⁰ A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
SINAI HOSPITAL | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE MARYLAND
B. COUNTY Baltimore
C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE
D. STREET ADDRESS (If rural, give location) 3715 Stoneybrook Rd | | | |
| 5. SEX
M | 6. RACE
W | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
MARRIED | 8. DATE OF BIRTH
XXXXXXXXXX | 9. AGE (In years lost birthday)
61 | If Under 1 Yr.
Months: Days: Hours: Min. | If Under 24 Hrs.
Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
WHITMAN AND CO. | | 10B. KIND OF BUSINESS OR INDUSTRY
BUILDING | | 11. BIRTHPLACE (State or foreign country)
Russia | | 12. CITIZEN OF WHAT COUNTRY?
USA. | |
| 13. FATHER'S NAME
ISAAC SCHWARTZ | | | | 14. MOTHER'S MAIDEN NAME
MINNIE ? | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
213-05-6052 | | 17. INFORMANT
MRS. GERTRUDE SCHWARTZ, 3715 STONEYBROOK ROAD. | | ADDRESS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
153.81
1) RECURRENT CA. of colon WITH SEVERE ANEMIA
2) ASCVD WITH RECURRENT CONGESTIVE HEART FAILURE AND MYOCARDIAL INFARCTION | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from APRIL 22, 1967 to APRIL 23, 1967 , that (I) (we) last saw the deceased alive on APRIL 23, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
[Signature] | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
4/23/67. | |
| 23C. PHYSICIAN'S NAME (Type)
[Signature] | | | | 23D. ADDRESS
M.D. SINAI HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
4/24/67 | | 24C. NAME of CEMETERY or CREMATORY
AN SHE EMUNAH - AITZ CHAIM | | 24D. LOCATION (City, town, or county) (State)
BALTIMORE, MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| APR 26 1967 | | [Signature] | | SQL LEVINSON & BROS INC., 6010 REIST., RD. | | | |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JOSEPH C. OCUS

2. DATE AND HOUR PRONOUNCED DEAD

4-21-67 8:52 AM

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

SINAI HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

420 Greenland Beach Road 21226

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

married

8. DATE OF BIRTH

Feb. 11, 1918

9. AGE (In years
last birthday)

49

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Sheet-Metal Worker

10B. KIND OF BUSINESS OR INDUSTRY

Fingles Co.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.

13. FATHER'S NAME

Charles Ocus

14. MOTHER'S MAIDEN NAME

Mary T. Mechura

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

218-03-9869

17. INFORMANT

Mrs. Dorothy Ocus (same)

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A)

Acute myocardial infarction

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

WERNER U. SPITZ, M.D.

ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

4-21-67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

4-24-1967

23C. NAME OF CEMETERY or CREMATORY

Holy Cross Cemetery

23D. LOCATION

(City, town, or county)

(State)

Ritchie Hgwy., A.A.Co., Maryland

24A. DATE REC'D BY HEALTH DEPT.

APR 26 1967

24B. NAME OF REGISTRAR

Robert E. Talley

24C. FUNERAL DIRECTOR

G.J. Gonce, 4001 Ritchie Hgwy., Baltimore, Md.

ADDRESS

X



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|--|----------------------------------|---|------------------------|--|
| BIRTH NO. 67 4092 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 4092 | |
| M.E. CASE NO. | | | 2. DATE AND HOUR OF DEATH | | |
| 1. NAME OF DECEASED
(Type or Print) Charles Rettkowski | | | 4/22/67 12:45 A.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND
CERTIFICATE AMENDED
5-1-67 | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Baltimore | | |
| 5. SEX Male | | | 6. RACE White | | |
| 7. MARRIED/NEVER MARRIED
WIDOWED, DIVORCED (specify) Widowed | | | 8. DATE OF BIRTH 8/29/1898 | | |
| 9. AGE (In years last birthday) 69 68 | | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber Helper | | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME Herman Rettkowski | | | 14. MOTHER'S MAIDEN NAME Martha Smith | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | 16. SOCIAL SECURITY NO. 214-14-2007 | | |
| 17. INFORMANT Mrs. Martha Marcantonio | | | ADDRESS 3734 821 S. Conley St. Baltimore | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
420.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)
ACUTE MYOCARDIAL INFARCTION
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
ARTERIO SCLEROTIC
CARDIOVASCULAR D.S. | | | CAUSE OF DEATH
(A) DUE TO
(B) DUE TO
(C) DUE TO | | |
| 19. DATE OF OPERATION 0 | | | 20. AUTOPSY? (Yes or No) Yes | | |
| 21. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 22. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 23. PHYSICIAN'S NAME (Type) R. Adams | | | 24. ADDRESS 1213 Light Street Balto. Md. 21230 | | |
| 25. DATE REC'D BY HEALTH DEPT. APR 26 1967 | | | 26. NAME OF REGISTRAR Robert E. Taylor | | |
| 27. FUNERAL DIRECTOR Nicholas T. Matthews | | | ADDRESS 3021 Eastern Ave. Baltimore, Md. | | |

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Certificate of Death | | Registered No. 67 4093 | | |
|--|--|--|--|---|---|---|---|--|
| BIRTH NO. 67 4093 | | M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) Evelyn Swanson | | 2. DATE AND HOUR OF DEATH
4/20/67 10:35 P.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Union Memorial Hospital | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Baltimore
C. CITY OR TOWN (If outside city limits, write RURAL and give township) 1-02
D. STREET ADDRESS (If rural, give location) 530 S. Decker Avenue | | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married | 8. DATE OF BIRTH 8/05/05 | 9. AGE (In years, lost birthday) 61 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | |
| 11. BIRTHPLACE (State or foreign country) Baltimore | | | 12. CITIZEN OF WHAT COUNTRY? USA | | | 13. FATHER'S NAME Charles Neimeyer | | |
| 14. MOTHER'S MAIDEN NAME Lillian Traut felter | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 216-12-6338 | | 17. INFORMANT Mr. Carl Swanson ADDRESS 530 S. Decker Ave, Baltimore Md. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Acute Pulmonary | | | | CAUSE OF DEATH
(A) Pulmonary atelectasis
(B) Emphysema + mediastinitis
(C) Secondary to esophageal perforation | | | | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | INTERVAL BETWEEN ONSET AND DEATH 4-17-4-20 | | | | |
| 19A. DATE OF OPERATION 4/17/67 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Cholelithiasis + hiatal hernia | | 20A. AUTOPSY? (Yes or No) YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (this hospital) attended the deceased from 4/14 19 67 to 4/20 19 67 ; that (we) lost saw the deceased alive on 4/20 19 67 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death. | | | | | | | | |
| 23A. SIGNATURE David S. Schwartz | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 4/20/67 | | |
| 23C. PHYSICIAN'S NAME (Type) DAVID S. SCHWARTZ, | | | | 23D. ADDRESS THE UNION MEMORIAL HOSPITAL | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 4-24-67 | | 24C. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR Robert E. Faulkner | | 25C. FUNERAL DIRECTOR Nicholas T. Matthews | | ADDRESS 3021 Eastern Ave, Baltimore, Md. | | |

Exhibit 10

NEW YORK

RECEIVED

RECEIVED

RECEIVED

NO

RECEIVED

RECEIVED

RECEIVED

RECEIVED

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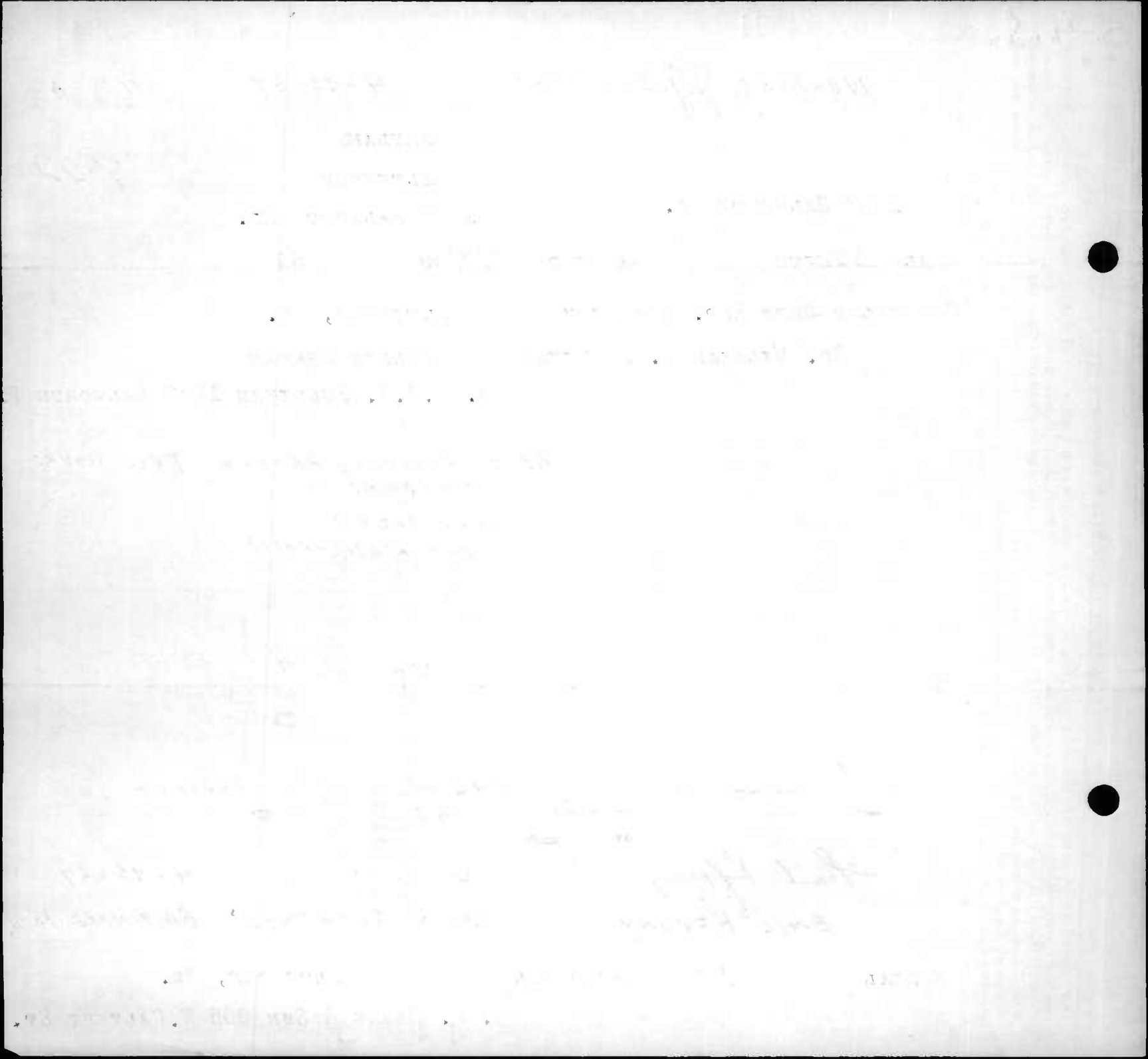
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|--|-------------------------|---|--|
| BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 4094 | |
| BIRTH NO. 67 4094 | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 2. DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED
(Type or Print) NORBERT J. J. SULLIVAN | | 4-22-67 11 A M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION

00 1657 RALWORTH RD. | | A. STATE
MARYLAND | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE | |
| | | D. STREET ADDRESS (If rural, give location)
1657 RALWORTH RD. | |
| 5. SEX
MALE | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
MARRIED | 8. DATE OF BIRTH
4/7/09 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
COUNSELOR DEPT EMP. SECURITY | | 10B. KIND OF BUSINESS OR INDUSTRY | 9. AGE (In years lost birthday)
58 |
| 13. FATHER'S NAME
DR. WILLIAM J. SULLIVAN | | 11. BIRTHPLACE (State or foreign country)
BALTIMORE, MD. | |
| 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service) | | 12. CITIZEN OF WHAT COUNTRY? | |
| 16. SOCIAL SECURITY NO. | | 14. MOTHER'S MAIDEN NAME
NELLIE SHEHAN | |
| 17. INFORMANT
MRS. N.J.J. SULLIVAN | | ADDRESS
1657 RALWORTH RD. | |
| 18. 4201 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)

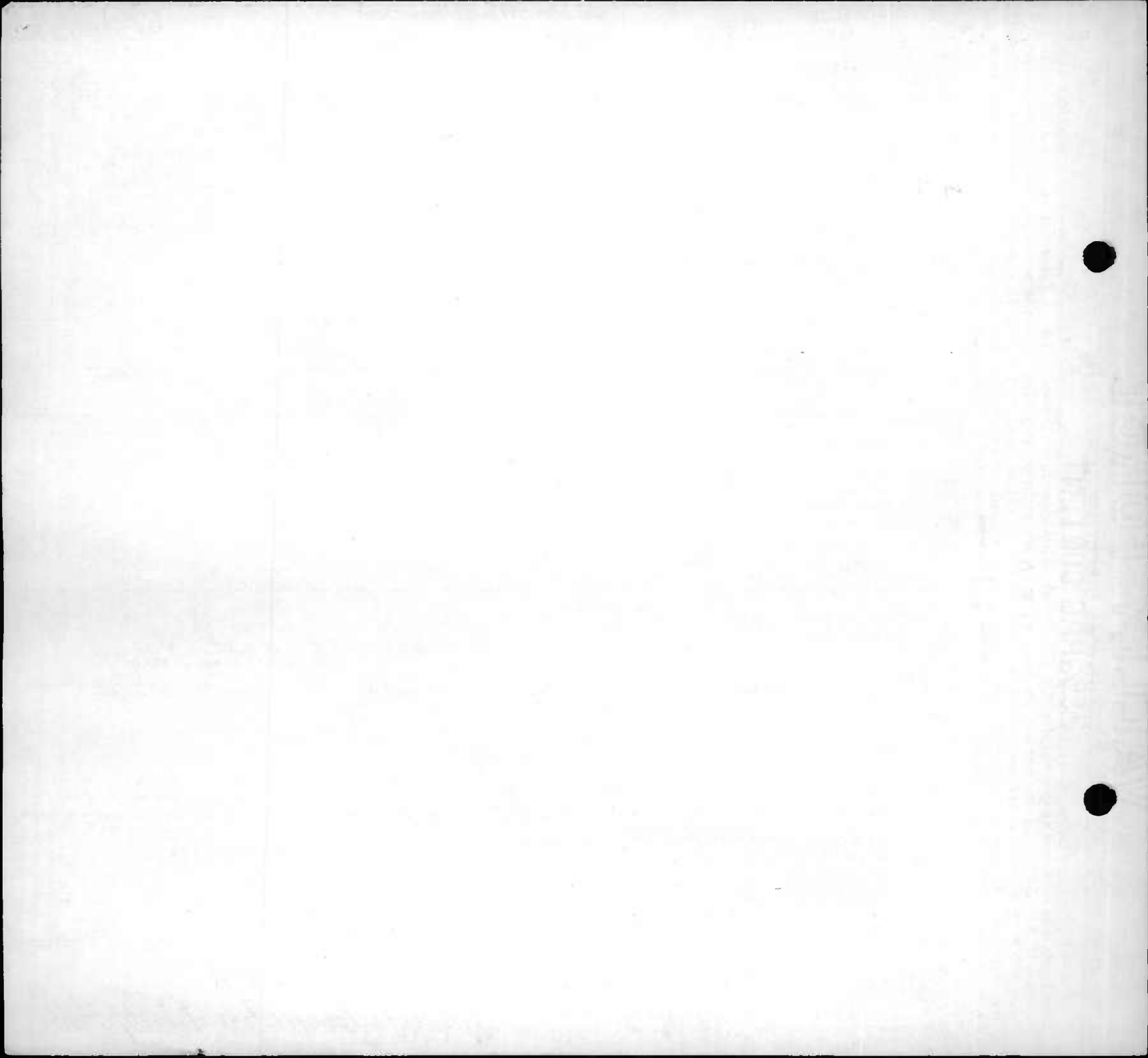
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) ACUTE CORONARY ARTERY THROMBOSIS
(B) GENERALIZED ARTERIOSCLEROSIS
(C) | |
| INTERVAL BETWEEN ONSET AND DEATH
FEW HOURS | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No)
No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (the hospital) attended the deceased from 1964 to PRESENT that (I) (we) last saw the deceased alive on 4-21 19 67 and that in (my) (the) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (do not) view the body after death. | | | |
| 23A. SIGNATURE
Emil Kfoury | | 23B. DATE SIGNED
4-22-67 | |
| 23C. PHYSICIAN'S NAME (Type)
EMIL KFOURY | | 23D. ADDRESS
100 N. BROADWAY BALTIMORE 18, MD. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
4/25/67 | |
| 24C. NAME OF CEMETERY or CREMATORY
CATHEDRAL | | 24D. LOCATION (City, town, or county) (State)
BALTIMORE, MD. | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 26 1967 | | 25B. NAME OF REGISTRAR
Robert E. Sullivan | |
| 25C. FUNERAL DIRECTOR
H. W. MEARS & SON | | ADDRESS
805 N. CALVERT ST. | |



FUNERAL DIRECTOR: IMPORTANT

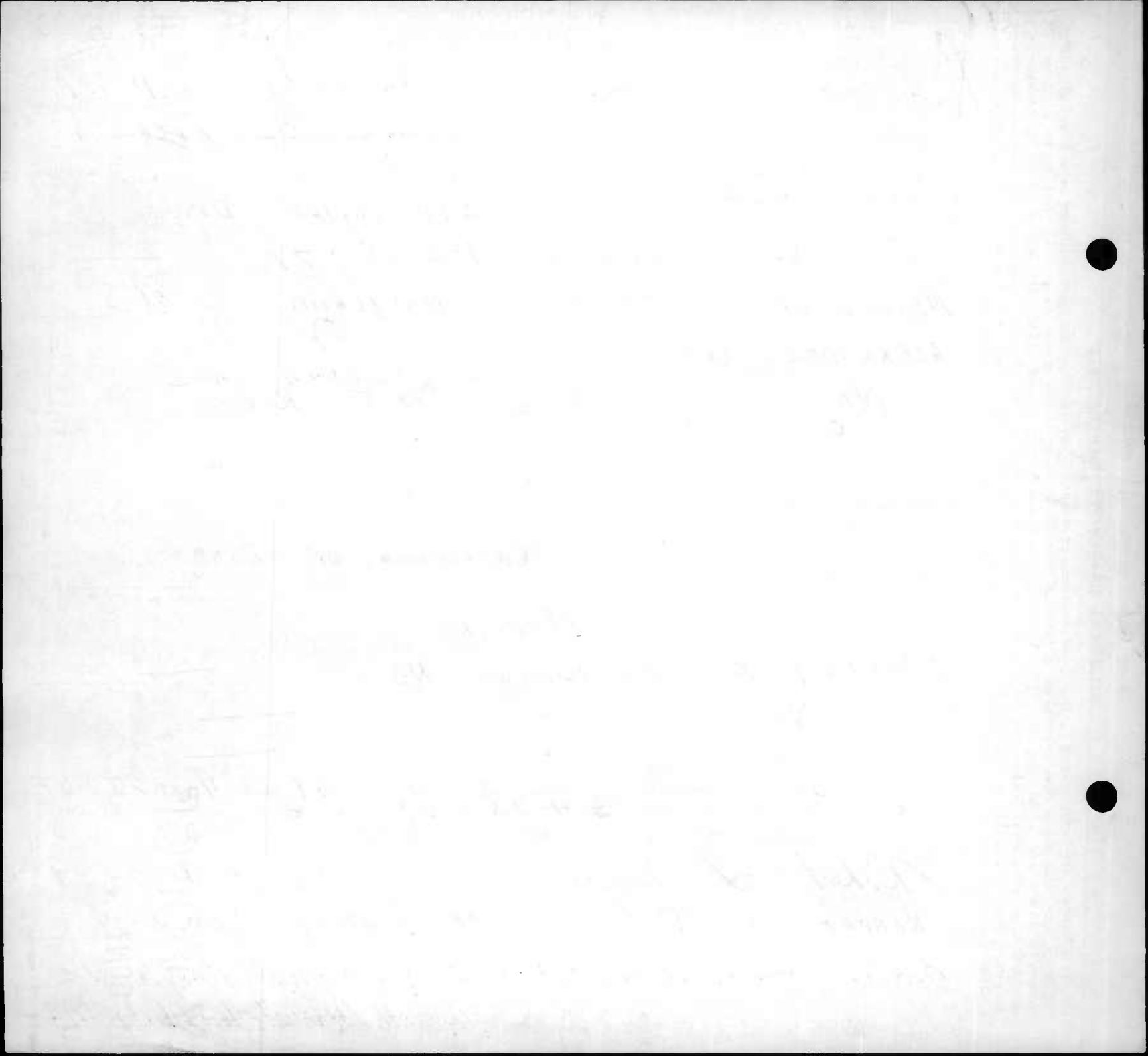
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|--|---|--|--|--|
| BIRTH NO. 67 4095 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 4095 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) OLIVER T. MANGUM | | | |
| 2. DATE AND HOUR OF DEATH
April 25 1967 5:35 P. M. | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND
Ht Union Memorial Hospital | | | |
| 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE MARYLAND
B. COUNTY BALTIMORE | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE | | | |
| D. STREET ADDRESS (If rural, give location)
5511 Groveland Ave | | 5. SEX MALE 6. RACE WHITE 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | | | |
| 8. DATE OF BIRTH
10-15-00 | | 9. AGE (In years last birthday) 66 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
MANAGER | |
| 11. BIRTHPLACE (State or foreign country)
MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
OLIVER WASHINGTON MANGUM | |
| 14. MOTHER'S MAIDEN NAME
LIELE MAE CHANEY | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
216-05-2359 | |
| 17. INFORMANT
CATHERINE MANGUM | | ADDRESS
SAME | | | |
| 18. 163X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
Carcinoma of Lung | | CAUSE OF DEATH
(A) DUE TO
(B) DUE TO
(C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH
? months | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from April 15 19 67 to April 25 19 67 , that (I) (we) last saw the deceased alive on April 25 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
James W. Carthy M.D. | | | | 23B. DATE SIGNED
4/25/67 | |
| 23C. PHYSICIAN'S NAME (Type)
James W. Carthy M.D. | | | | 23D. ADDRESS
Union Memorial Hospital | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
4-28-67 | | 24C. NAME OF CEMETERY or CREMATORY
David Ridge Cemetery | |
| 24D. LOCATION (City, town, or county) (State)
BALTO, Md | | 25A. DATE REC'D BY HEALTH DEPT.
APR 26 1967 | | | |
| 25B. NAME OF REGISTRAR
Robert E. Taylor | | 25C. FUNERAL DIRECTOR
Ellsworth Armacost-4600 Liberty Hgts | | | |
| 25D. ADDRESS
Ellsworth Armacost-4600 Liberty Hgts | | | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

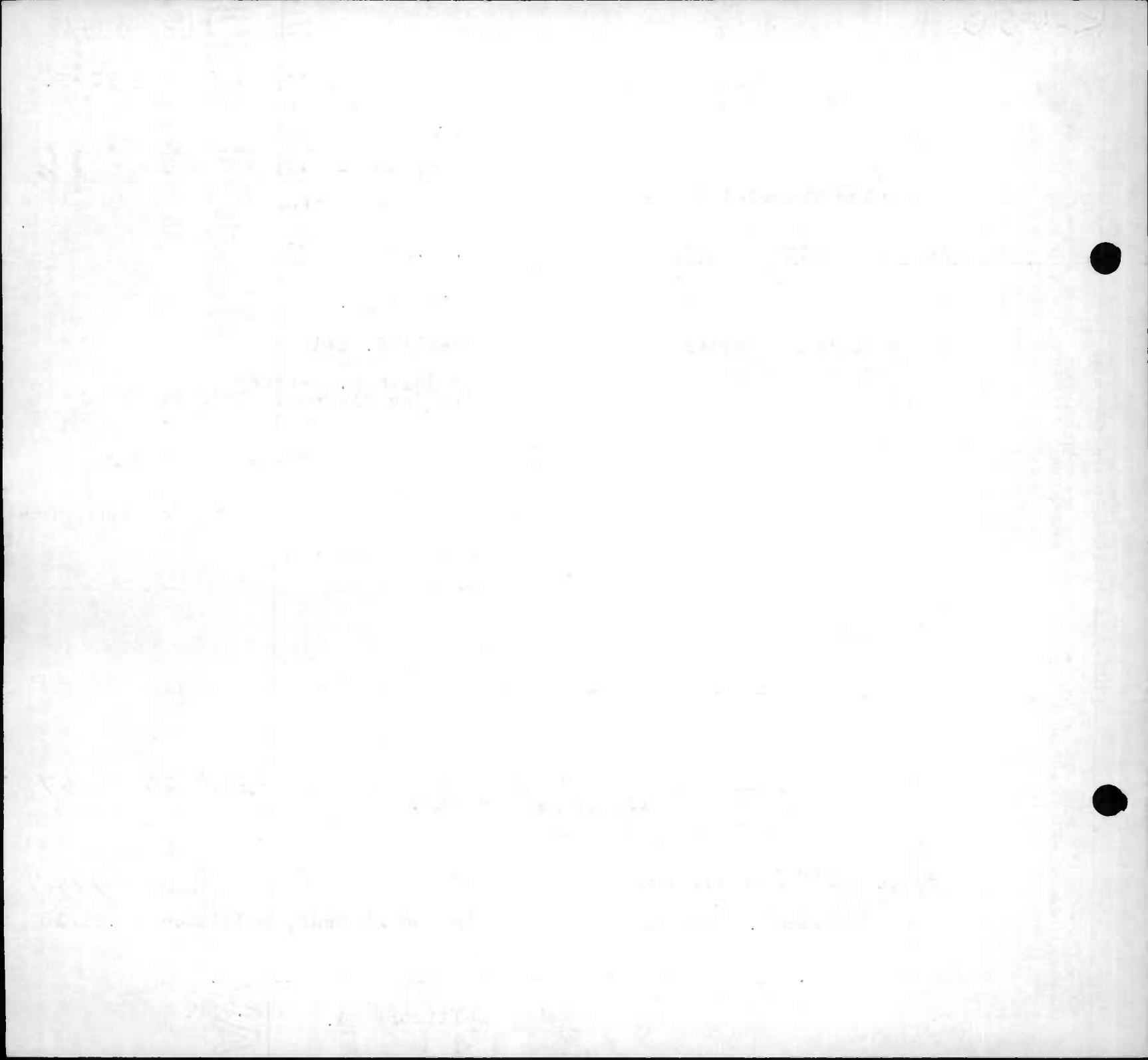
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Certificate of Death | | Registered No. | |
|--|------------------|---|------------------------------------|---|--|---|---|
| BIRTH NO. 67 4096 | | | | 67 4096 | | | |
| M.E. CASE NO. | | | | DATE AND HOUR OF DEATH | | | |
| 1. NAME OF DECEASED
(Type of ship) BERTHA E. Gundlach. | | | | 4-23-67 11:15 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence, before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location)
UNIVERSITY OF MARYLAND HOSPITAL
REDWOOD + GREENE ST | | | | A. STATE BALTIMORE | | | |
| | | | | B. COUNTY BALTIMORE | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE | | | |
| | | | | D. STREET ADDRESS (If rural, give location)
2411 Poplar Drive | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
UNMARRIED | 8. DATE OF BIRTH
1-30-88 | 9. AGE (In years last birthday)
79 | If Under 1 Yr. Months: Days: Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWIFE | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
U.S. |
| 13. FATHER'S NAME
ALEXANDER LUNRWICK | | | | 14. MOTHER'S MAIDEN NAME
Gundlach | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | | | 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT
Gundlach - Same Chart Record | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
Wide spread METASTATIC CARCINOMA - | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
ANEMIA | | | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION
13-27-67 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
BLADDER TUMOR | | 20A. AUTOPSY? (Yes or No)
NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
NO | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (this hospital) attended the deceased from 3-11-1967 to 4-23-1967 , that (we) last saw the deceased alive on 4-23-1967 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
Robert L. Doyle M.D. | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
4-23-67 | |
| 23C. PHYSICIAN'S NAME (Type)
ROBERT L. DOYLE M.D. | | | | 23D. ADDRESS
UNIVERSITY HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
4-26-67 | | 24C. NAME OF CEMETERY or CREMATORY
LONDON PARK Cemetery | | 24D. LOCATION (City, town, or county) (State)
BALTIMORE, MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR
Robert L. Doyle | | 25C. FUNERAL DIRECTOR
Ellsworth Arnacost | | ADDRESS
4600 Liberty Heights | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|--|-------------------------|---|--|
| BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 4097 | |
| BIRTH NO. 67 4097 | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED
(Type or Print) MARCELLA ANGELA KEARNEY | | 2. DATE AND HOUR OF DEATH
APRIL 22, 1967 6:30 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
44 Union Memorial Hospital | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore - 21218
D. STREET ADDRESS (If rural, give location)
2711 The Alameda | |
| 5. SEX
Female | 6. RACE
White | 7. MARRIED, NEVER MARRIED
Single | 8. DATE OF BIRTH
Apr. 17, 1887 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Clerk | | 10B. KIND OF BUSINESS OR INDUSTRY
Retired | 9. AGE (In years last birthday)
80 |
| 11. BIRTHPLACE (State or foreign country)
Baltimore Md. | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
James Francis Kearney | | 14. MOTHER'S MAIDEN NAME
Marcella A. Cain | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
no | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
Miss Julia M. Kearney | | ADDRESS
2711 The Alameda, Baltimore 21218 | |
| 18. 4-20-11
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osteonia, etc. It means the disease, injury or complication which caused death.)
Coronary Thrombosis | | INTERVAL BETWEEN ONSET AND DEATH
1 day | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Arterio-sclerotic Cardio | | 8 months | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Vascular Disease | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No)
No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | |
| 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Aug 5 1966 to April 22 1967 , that (I) (we) last saw the deceased alive on April 18 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE
Charles W. Edmonds | | 23B. DATE SIGNED
April 24, 1967 | |
| 23C. PHYSICIAN'S NAME (Type)
CHARLES W. EDMONDS | | 23D. ADDRESS
2746 The Alameda, Baltimore Md. 21218 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
Apr. 26, 1967 | |
| 24C. NAME OF CEMETERY or CREMATORY
New Cathedral Cemetery | | 24D. LOCATION (City, town, or county) (State)
Baltimore Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 20 1967 | | 25B. NAME OF REGISTRAR
Henry Sander & Sons, Inc. | |
| 25C. FUNERAL DIRECTOR
Baltimore Md. | | ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

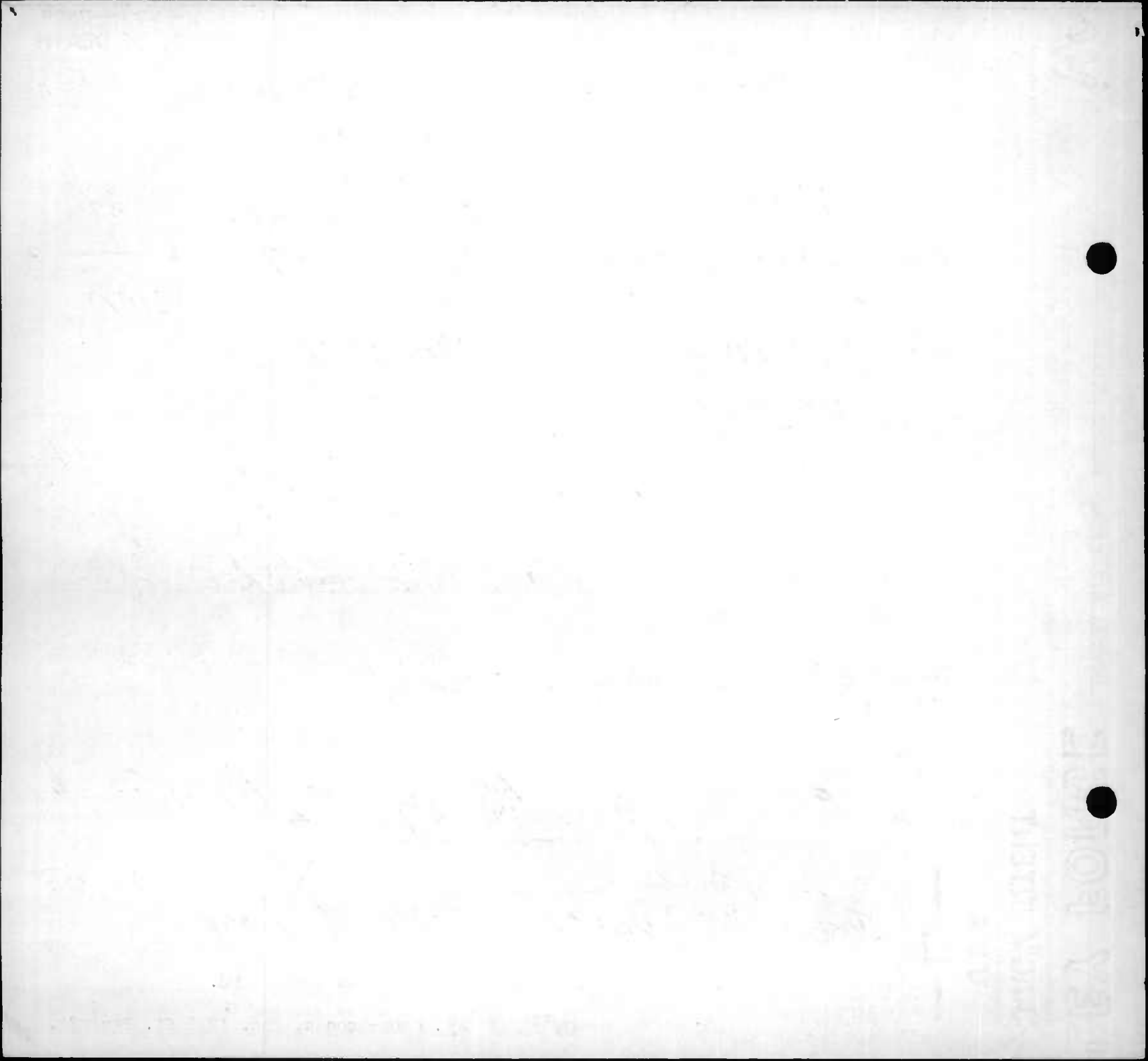
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | |
|---|---------------------|--|---|--|--|--|-----------------------------|--|-------------------------------------|--|
| BIRTH NO. 67 4098 | | | | | REGISTERED NO. 67 4098 | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | |
| M.E. CASE NO. | | | | | 2. DATE AND HOUR OF DEATH | | | | | |
| 1. NAME OF DECEASED
(Type or Print) <u>Ruth N. Hensell</u> | | | | | April 24 1967 4:40 P.M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<u>Maryland General Hospital</u> | | | | | A. STATE <u>Maryland</u>
B. COUNTY | | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>Baltimore</u> | | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location)
<u>1923 St. Paul St.</u> | | | | | |
| 5. SEX
<u>F</u> | 6. RACE
<u>W</u> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<u>widowed separated</u> | 8. DATE OF BIRTH
<u>5/10/92</u> | 9. AGE (In years last birthday)
<u>74</u> | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Drillpress Oper.</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>Jeroder - May Corp.</u> | | 11. BIRTHPLACE (State or foreign country)
<u>W. Va.</u> | | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A</u> | | |
| 13. FATHER'S NAME
<u>Charles Barrett</u> | | | | | 14. MOTHER'S MAIDEN NAME | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>No</u> | | | 16. SOCIAL SECURITY NO.
<u>214-09-6451</u> | | 17. INFORMANT
<u>Arthur Hensell</u>
(son) | | | ADDRESS
<u>same</u> | | |
| 18. <u>420.01</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)
<u>ARTERIOSCLEROTIC HEART DISEASE</u> | | | | | CAUSE OF DEATH
(A) DUE TO
(B) DUE TO
(C) DUE TO | | | | | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| II | | | | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | |
| 19A. DATE OF OPERATION
<u>2</u> | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No)
<u>Yes</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
<u>Yes</u> | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (<u>this hospital</u>) attended the deceased from <u>April 24</u> 19 <u>67</u> to <u>April 24</u> 19 <u>67</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>April 24</u> 19 <u>67</u> and that in (my) (<u>our</u>) opinion death occurred on the date and hour and from the causes stated above. (I) (<u>we</u>) (<u>did</u>) (<u>did not</u>) view the body after death. | | | | | | | | | | |
| 23A. SIGNATURE
<u>W. Michael Gould</u> | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | 23B. DATE SIGNED
<u>4/24/67</u> | | |
| 23C. PHYSICIAN'S NAME (Type)
<u>W. Michael Gould, M.D.</u> | | | | | 23D. ADDRESS
M.D. | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | | 24B. DATE
<u>4/28/67</u> | | 24C. NAME of CEMETERY or CREMATORY
<u>Rest Haven Cemetery</u> | | | 24D. LOCATION (City, town, or county) (State)
<u>Hagerstown, Md.</u> | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | | 25B. NAME OF REGISTRAR
<u>A. B. E. Taylor</u> | | | 25C. FUNERAL DIRECTOR
<u>Wm. Cook-Brooks, Inc.</u> | | | ADDRESS
<u>1217 St. Paul St.</u> | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | |
|--|-------------------------|---|---|---|---|---|--|--|-------------------------------------|--|
| CERTIFICATE OF DEATH | | | | | Registered No. 67 4099 | | | | | |
| BIRTH NO. 67 4099 | | M.E. CASE NO. | | | 1. NAME OF DECEASED
(Type or Print) JOHN COURTNEY | | | 2. DATE AND HOUR OF DEATH
4/24/67 1250 A.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
37 Mercy Hosp. | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE
D. STREET ADDRESS (If rural, give location)
11520 MULBERRY ST. | | | | | |
| 5. SEX
MALE | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
SINGLE | 8. DATE OF BIRTH
8/24/00 | 9. AGE (In years last birthday)
67 | If Under 1 Yr. Months: Days: Hours: Min. | | 12. CITIZEN OF WHAT COUNTRY?
USA | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
WAITER | | | 10B. KIND OF BUSINESS OR INDUSTRY
? | | 11. BIRTHPLACE (State or foreign country)
MASS. | | | 12. CITIZEN OF WHAT COUNTRY?
USA | | |
| 13. FATHER'S NAME
John Courtney | | | | | 14. MOTHER'S MAIDEN NAME
MARY ? | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
UNKNOWN | | | 16. SOCIAL SECURITY NO.
376-05-1644 | | 17. INFORMANT
MRS. VIRGINIA BEARD | | | ADDRESS
115 W. Mulberry St. | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
002.14381.1 | | | | | CAUSE OF DEATH
BACTERIAL PNEUMONITIS
DUE TO pos Active TBC
CMT w ASCUTD
(B) DUE TO pos Lane's Cushing & OBST. PULM DISEASE | | | INTERVAL BETWEEN ONSET AND DEATH
< 4 days
4 yrs
2 yrs | | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | |
| 19A. DATE OF OPERATION
4/23/67 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
tracheostomy for resp distress | | | 20A. AUTOPSY? (Yes or No)
YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
? | | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (this hospital) attended the deceased from April 21, 1967 to April 24, 1967 .
that (we) last saw the deceased alive on April 24, 1967 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death. | | | | | | | | | | |
| 23A. SIGNATURE
Dr. M. France M.D. | | | | | | | 23B. DATE SIGNED
4/24/67 | | | |
| 23C. PHYSICIAN'S NAME (Type)
JOSEPH M. FRANCE M.D. | | | 23D. ADDRESS
Mercy Hosp. | | | | | | | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
4/27/67 | | 24C. NAME OF CEMETERY OR CREMATORY
Loudon Park Cemetery | | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 26 1967 | | | 25B. NAME OF REGISTRAR
Robert E. Johnson | | | 25C. FUNERAL DIRECTOR
Wm. Cook-Brooks, Inc. | | | ADDRESS
1217 St. Paul St. | |



2-212

67 4100

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 4100

BIRTH NO.

M.E. CASE NO.

| | | | | | | | |
|--|-----------------------------------|--|---|--|---|---|--|
| 1. NAME OF DECEASED
(Type or Print)
WILLIE J. JACOBS | | | | 2. DATE AND HOUR PRONOUNCED DEAD
4-24-67 5:55 PM M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
CHURCH HOME AND HOSPITAL - DOA | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY 1-05
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
2219 E. Baltimore Street 21231 | | | |
| 5. SEX
Male | 6. RACE
American Indian | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)
Married | 8. DATE OF BIRTH
April 29, 1941 | 9. AGE (In years last birthday)
26 25 | If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Painter | | 10B. KIND OF BUSINESS OR INDUSTRY
G&H Paint Company | | 11. BIRTHPLACE (State or foreign country)
North Carolina | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Henry Jacobs | | | | 14. MOTHER'S MAIDEN NAME
Martla Clark | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
Biggs Funeral Home Lumberton, North Carolina | | | |
| 18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
Gunshot wounds of head and abdomen
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
Yes | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
Home | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
2nd Floor Front 2219 E. Baltimore Street 1-05 | | | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) 4- 24 '67 | | 21E. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR?
Shot by wife during altercation | | | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>
CHIEF MEDICAL EXAMINER <input type="checkbox"/>
DATE SIGNED 4-25-67
ACTUAL SIGNATURE Werner U. Spitz M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
EXAMINER'S NAME (Type) WERNER U. SPITZ, M.D. ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | | | | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 23B. DATE
4-29-67 | | 23C. NAME OF CEMETERY or CREMATORY
Jacobs Family Cemetery | | 23D. LOCATION (City, town, or county) (State)
Robeson County North Carolina | |
| 24A. DATE REC'D BY HEALTH DEPT.
APR 26 1967 | | 24B. NAME OF REGISTRAR
Robert E. Taylor | | 24C. FUNERAL DIRECTOR ADDRESS
Wm. Cook-Brooks Inc. 1217 St PAUL St Bklt. 2, MD | | | |

N9031 4670004100

WILLIAM H. MOORE

Wm. H. Moore & Co. Inc.
1512+ 5th St.
New York, N.Y.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | |
|---|--------------|---|---|--|---|--|--|--|---|------------------------|--|
| CITY HEALTH DEPARTMENT | | | | | Registered No. | | | | | | |
| BIRTH NO. | | 67 4101 | | | CITY HEALTH DEPARTMENT | | | | | Registered No. 67 4101 | |
| M.E. CASE NO. | | 67 4101 | | | CITY HEALTH DEPARTMENT | | | | | Registered No. 67 4101 | |
| 1. NAME OF DECEASED
(Type or Print) William Alexander Goudreau | | | | | 2. DATE AND HOUR OF DEATH
April 24, 1967 10:35 A.M. | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
US Public Health Service Hospital
Wyman Pk. Drive & 31st St. | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Michigan
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Box 144
D. STREET ADDRESS (If rural, give location)
Guilliver | | | | | | |
| 5. SEX
M | 6. RACE
W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
Married | | 8. DATE OF BIRTH
8/11/98 | 9. AGE (In years lost birthday)
68 | 10. CITIZEN OF WHAT COUNTRY?
USA | | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Keeper lighthouse | | | | 10B. KIND OF BUSINESS OR INDUSTRY
Light House | | 11. BIRTHPLACE (State or foreign country)
Mich. | | | | | |
| 13. FATHER'S NAME
Alexander Goudreau | | | | | 14. MOTHER'S MAIDEN NAME
Eliza Walker | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
yes USA 1918 | | | | 16. SOCIAL SECURITY NO.
379-10-6830 | | 17. INFORMANT ADDRESS
Records- US PHS Hospital, Balto, Md. | | | | | |
| 18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Peritonitis
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Ruptured colon
Hodgkin's disease
INTERVAL BETWEEN ONSET AND DEATH
Days
Days
Years | | | | | | | | | | | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | |
| 19A. DATE OF OPERATION
2 | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No)
yes | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
yes | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)
(APPROX.) | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (1) (this hospital) attended the deceased from Mar. 22 1967, to Apr. 24 1967, that (1) (we) last saw the deceased alive on Apr. 24 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE
Michael E. Pelczar M.D. | | | | | | | | | 23B. DATE SIGNED
4/24/67 | | |
| 23C. PHYSICIAN'S NAME (Type)
Michael E. Pelczar, SA Surg (R) | | | | | | 23D. ADDRESS
US PHS Hospital, Balto, Md. | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | | 24B. DATE
4-29-67 | | 24C. NAME OF CEMETERY OR CREMATORY
FAIRVIEW CEMETERY | | | 24D. LOCATION (City, town, or county) (State)
MANISTIQUE MICHIGAN | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | | 25B. NAME OF REGISTRAR
Wm. Cook-Brooks Inc. | | | 25C. FUNERAL DIRECTOR ADDRESS
1217 St. Paul Street | | | | | |

Michael E. Palazzo

Michael E. Palazzo, Esq. (7)

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

RG

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 4102 | |
|--|---------------------|--|---|--|--|
| BIRTH NO. 67 4102 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) Antonio Carrano | | 2. DATE AND HOUR OF DEATH
April 23, 1967 7:10 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
US Public Health Service Hospital
Wyman Pk. Drive & 31st Street | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
718 S. Broadway | | | |
| 5. SEX
M | 6. RACE
W | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Div. | 8. DATE OF BIRTH
2/28/06 | 9. AGE (In years last birthday)
61 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Messman | | 10B. KIND OF BUSINESS OR INDUSTRY
Seafarer | | 11. BIRTHPLACE (State or foreign country)
Conn. | |
| 13. FATHER'S NAME
Louis Carrano | | | 14. MOTHER'S MAIDEN NAME
Margaret Datri | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give service)
Yes USN 1922-1934 1940-1943 | | 16. SOCIAL SECURITY NO.
049-03-1108 | | 17. INFORMANT ADDRESS
Records- US PHS Hospital, Balto, Md. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, assthenia, etc. It means the disease, injury or complication which caused death.)
Bronchopneumonia | | CAUSE OF DEATH
(A) DUE TO
Atelectasis | | INTERVAL BETWEEN ONSET AND DEATH
Days | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO | | Days | |
| (C) DUE TO | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | Nutritional cirrhosis | | Months | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I)/(this hospital) attended the deceased from Apr. 13 1967 to Apr. 23 1967 , that (I)/(we) last saw the deceased alive on Apr. 23 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I)/(We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Michael E. Pelczar M.D. | | | | 23B. DATE SIGNED
4/24/67 | |
| 23C. PHYSICIAN'S NAME (Type)
Michael E. Pelczar, SA Surg (R) | | 23D. ADDRESS
US PHS Hospital, Balto, Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
4/27/67 | | 24C. NAME OF CEMETERY or CREMATORY
St. Michael's Cemetery | |
| 24D. LOCATION (City, town, or county) (State)
Bridgeport, Connecticut | | 25A. DATE REC'D BY HEALTH DEPT.
APR 26 1967 | | | |
| 25B. NAME OF REGISTRAR
Robert E. Gaby | | 25C. FUNERAL DIRECTOR ADDRESS
Wm. Cook-Brooks, Inc. 1217 St. Paul St. | | | |

Michael C. Plesner

FUNERAL DIRECTOR: IMPORTANT

ertificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|---------------------|--|--|---|--|--|--|-----------------------------|--|
| 67 4103 | | | | | 67 4103 | | | | |
| BIRTH NO. | | | | | CERTIFICATE OF DEATH | | | | |
| M.E. CASE NO. | | | | | 2. DATE AND HOUR OF DEATH | | | | |
| 1. NAME OF DECEASED
(Type or Print) <i>MIRIAM M. Straus</i> | | | | | 4. 23-67 4:06 M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<i>42 SINAL</i> | | | | | A. STATE <i>MD</i>
B. COUNTY | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<i>Baltimore</i> | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location)
<i>2305 South Road</i> | | | | |
| 5. SEX
<i>F</i> | 6. RACE
<i>W</i> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<i>Widowed</i> | | 8. DATE OF BIRTH
<i>2.15.92</i> | 9. AGE (In years last birthday)
<i>75</i> | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Housewife</i> | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<i>Baltimore, Maryland</i> | | 12. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | |
| 13. FATHER'S NAME
<i>Bernard Moses</i> | | | | | 14. MOTHER'S MAIDEN NAME
<i>Bertha Manko</i> | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>No None</i> | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
<i>1027 East 24th St. Mrs. Nancy S. Winner Iowa City, Iowa</i> | | | | |
| 18. <i>134X I</i>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
<i>Carcinoma Recto-sigmoid</i>
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
<i>Sub-phrenic abscess</i>
<i>Myocardial Infarction</i> | | | | | CAUSE OF DEATH
(A) DUE TO
(B) DUE TO
(C) DUE TO | | | | |
| INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION
<i>Last: 4.10.67</i> | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
<i>Sub-phrenic abscess</i> | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>4.23.67</i> to <i>4.23.67</i> , that (I) (we) last saw the deceased alive on <i>4.23.67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
<i>R. Theodore</i> | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
<i>4.23.67</i> | | |
| 23C. PHYSICIAN'S NAME (Type)
<i>ROGER THEODORE</i> | | | | | 23D. ADDRESS
<i>M.D.</i> | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Cremation</i> | | 24B. DATE
<i>4/26/1967</i> | | 24C. NAME OF CEMETERY or CREMATORY
<i>Loudon Park Cemetery</i> | | 24D. LOCATION (City, town, or county) (State)
<i>Baltimore, Md.</i> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | | 25B. NAME OF REGISTRAR
<i>APR 26 1967</i> | | 25C. FUNERAL DIRECTOR ADDRESS
<i>Wm. F. Tupper & Sons Balto. Md.</i> | | | | |

22.1-3

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 4104 | |
|---|--|--|--|---|--|
| BIRTH NO. 67-670264104 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) BABY BOY LOGAN | | | |
| 2. DATE AND HOUR OF DEATH
4-9-67 5:15 A.M. | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND
UNIVERSITY HOSP. | | | |
| 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD.
B. COUNTY BALTO. | | 5. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTO. | | | |
| 6. STREET ADDRESS (If rural, give location)
816 NEWINGTON AVE. 21217. | | 7. DATE OF BIRTH 4-7-67 | | | |
| 8. AGE (In years last birthday) 2 | | 9. If Under 1 Yr. Months Days | | 10. If Under 24 Hrs. Hours Min. | |
| 11. BIRTHPLACE (State or foreign country) BALTO. MD. | | 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME MICHAEL JONES. | |
| 14. MOTHER'S MAIDEN NAME PATRICIA LOGAN | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT U. H. Hunt II 344760 | | ADDRESS | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
7. Massive infarctus | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH
36 hrs. | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) DUE TO | | (B) DUE TO | |
| (C) DUE TO | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Prematurity. | | TS | |
| 20. DATE OF OPERATION | | 21. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 22. AUTOPSY? (Yes or No) | |
| 23. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 24. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 25. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 26. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 27. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) | | 28. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 29. HOW DID INJURY OCCUR? | | 30. I certify that (1) (this hospital) attended the deceased from 4-9 19 67 to 4-9 19 67 , that (1) (we) last saw the deceased alive on 4-9 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | |
| 31. SIGNATURE Albert M. Gordon | | 32. DATE SIGNED 4-9-67 | | 33. PHYSICIAN'S NAME (Type) Albert M. Gordon | |
| 34. ADDRESS | | 35. DATE | | 36. NAME OF CEMETERY or CREMATORY | |
| 37. LOCATION (City, town, or county) (State) | | 38. DATE REC'D BY HEALTH DEPT. | | 39. NAME OF REGISTRAR | |
| 40. FUNERAL DIRECTOR | | 41. MORTUARY SERVICE - BCHD | | 42. APR 26 1967 | |

Albert M. Gordon

4-20-63

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | Registered No. <u>67 4105</u> | |
|---|-------------------------|---|--|---|---|--|---|
| BIRTH NO. <u>67-06362</u> | | 67 4105 | | | | | |
| M.E. CASE NO. | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) <u>Finney, Baby Boy</u> | | | | 2. DATE AND HOUR OF DEATH
<u>3-28-67</u> <u>7:45</u> P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <u>md.</u> B. COUNTY <u>-</u> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<u>UNIVERSITY</u> | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>Baltimore</u> | | | |
| | | | | D. STREET ADDRESS (If rural, give location)
<u>904 W. Lexington St.</u> | | | |
| 5. SEX
<u>Male</u> | 6. RACE
<u>Negro</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
<u>Never married</u> | | 8. DATE OF BIRTH
<u>3-28-67</u> | 9. AGE (In years last birthday)
<u>7</u> | 10. Under 1 Yr. Months: Days: <u>7</u> <u>13</u> | 11. Under 24 Hrs. Hours: Min. <u>13</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Infant</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>-</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Balto, md</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME
<u>Sharon Finney</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>-</u> | | 17. INFORMANT
<u>Chart</u> | | ADDRESS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
<u>226X1</u> | | | | CAUSE OF DEATH
(A) <u>Premature Infant</u>
DUE TO | | INTERVAL BETWEEN ONSET AND DEATH
<u>Life</u> | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) DUE TO | | | |
| | | | | (C) DUE TO | | | |
| II | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION
<u>0 None</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
<u>-</u> | | 20A. AUTOPSY? (Yes or No)
<u>-</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<u>No</u> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
<u>-</u> | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
<u>-</u> | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
<u>-</u> | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR?
<u>-</u> | | | |
| 22. I certify that he (this hospital) attended the deceased from <u>12:45 pm</u> <u>3-28-67</u> to <u>7:45 pm</u> <u>3-28-67</u> , that he (we) last saw the deceased alive on <u>3-28-67</u> and that in the (our) opinion death occurred on the date and hour and from the causes stated above. He (We) (did) not view the body after death. | | | | | | | |
| 23A. SIGNATURE
<u>Edward J. Ruley, M.D.</u> | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
<u>3-28-67</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>Edward J. Ruley, M.D.</u> | | | | 23D. ADDRESS
<u>University Hospital</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>4-20-67</u> | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY
<u>JOHNS HOPKINS MEDICAL SCHOOL</u> | | 24D. LOCATION (City, town, or county) (State)
<u>MARYLAND</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR
<u>Edw. J. Ruley, M.D.</u> | | 25C. FUNERAL DIRECTOR
<u>MORTUARY SERVICE - BCHD</u> | | ADDRESS | |

Family Policy

3-28-03

5-2-0

104 W Washington CT
Baltimore

Mark R. Jones 8-28-03

5-2-0

Index - Baltimore Md

Sharon French

No - Chart

Prescriptive Index

More

No

3-28-03

1-2-0

5-2-0

Edward J. Kelly MD

University Hospital

3-28-03

X

3-28-03

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 4106 | |
|--|-------------------|--|---|--|-------------------------------------|
| BIRTH NO. 67 4106 | | | | M.E. CASE NO. | |
| 1. NAME OF DECEASED
(Type or Print) OVERBY BABY GIRL. | | | | 2. DATE AND HOUR OF DEATH
3.31.67. 1.00 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location)
UNIVERSITY HOSPITAL OF MARYLAND.
38 | | | A. STATE
B. COUNTY
Maryland. | | |
| | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore #18. 12-04 | | |
| | | | D. STREET ADDRESS (If rural, give location)
2206 Barclay St. | | |
| 5. SEX
F. | 6. RACE
NEGRO. | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH
3 29.67. | 9. AGE (In years last birthday) | 10. CITIZEN OF WHAT COUNTRY?
USA |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
NEWBORN. | | | 10B. KIND OF BUSINESS OR INDUSTRY
NEWBORN | | |
| 11. BIRTHPLACE (State or foreign country)
UNIVERSITY HOSPITAL. BALD. | | | 12. CITIZEN OF WHAT COUNTRY?
USA | | |
| 13. FATHER'S NAME
JAMES OVERBY. | | | 14. MOTHER'S MAIDEN NAME
DELORES FINCH. | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | |
| 17. INFORMANT | | | ADDRESS | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
776X I
IMMATURE NEWBORN, female. 38 hr. | | | INTERVAL BETWEEN ONSET AND DEATH
38 hr. | | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
0 - | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 3, 30 19 67 to 3, 31 19 67, that (I) (we) last saw the deceased alive on March 31 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
P. Delasuban | | | | 23B. DATE SIGNED
3.31.67. | |
| 23C. PHYSICIAN'S NAME (Type)
PUANAPETCH SETASUBAN | | | | 23D. ADDRESS
1514 DIVISION ST. BALTO. MD #2127 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
4-20-67 | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY
JOHNS HOPKINS MEDICAL SCHOOL | |
| 24D. LOCATION (City, town, or county) (State) | | 24E. NAME OF REGISTRAR
APR 26 1967 P. Delasuban | | 24F. FUNERAL DIRECTOR
MORTUARY SERVICE - BCHD | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |

THE UNIVERSITY OF CHICAGO
LIBRARY

100-1000

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. <u>67-4107</u>
<u>67-08237</u> | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. <u>67 4107</u> | |
|---|---------------------|---|------------------------------------|---|---|--|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) <u>Baby Boy Brown</u> | | | | 2. DATE AND HOUR OF DEATH
<u>4-10-67</u> <u>5:15 A.M.</u> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<u>Lutheran Hospital of Md.</u>
<u>46</u> | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <u>md.</u>
B. COUNTY <u>Balto</u>
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>16-87</u>
D. STREET ADDRESS (If rural, give location)
<u>3009 Preston ST.</u> | | | |
| 5. SEX
<u>M</u> | 6. RACE
<u>C</u> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<u>-</u> | 8. DATE OF BIRTH
<u>4-10-67</u> | 9. AGE (In years last birthday)
<u>-</u> | If Under 1 Yr.
Months: Days: Hours: Min.
<u>1</u> <u>50</u> | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>md.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> |
| 13. FATHER'S NAME
<u>Ronald Levi Brown</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Pearson</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>-</u> | | 16. SOCIAL SECURITY NO.
<u>-</u> | | 17. INFORMANT ADDRESS | | | |
| 18. <u>776X I</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | CAUSE OF DEATH
(A) <u>Immaturity</u>
DUE TO
(B) <u>-</u>
DUE TO
(C) <u>-</u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>1 hr. 50 min.</u> | |
| 19A. DATE OF OPERATION
<u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<u>No</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>3:30 PM, 4/10, 1967</u> to <u>5:15 AM 4/10, 1967</u> , that (I) (we) last saw the deceased alive on <u>5:15 AM 4/10, 1967</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
<u>[Signature]</u> | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
<u>4/10/67</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>S. Kim</u> | | | | 23D. ADDRESS
M.D. <u>Lutheran Hospital, Baltimore, Md.</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>4-16-67</u> | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State)
<u>UNIVERSITY MEDICAL SCHOOL</u> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>APR 26 1967</u> | | 25B. NAME OF REGISTRAR
<u>[Signature]</u> | | 25C. FUNERAL DIRECTOR ADDRESS
<u>MORTUARY SERVICE - BCHD</u> | | | |

4-10-13

1
2-520

67 4108

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 4108

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JAMES LYNCH

2. DATE AND HOUR PRONOUNCED DEAD

April 20, 1967 6:45 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

38 University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

236 N. Pine Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

?

8. DATE OF BIRTH

1910

9. AGE (In years
last birthday)

57

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Halifax, N Carolina

12. CITIZEN OF
WHAT COUNTRY?

U S A

13. FATHER'S NAME

James J Lynch

14. MOTHER'S MAIDEN NAME

Lucy

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

17. INFORMANT

Mrs Helen Lynch

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

Lobar and Broncho-pneumonia

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Fatty liver

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20. AUTOPSY (Yes or No)

Partial
Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

April 21, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

4/28/67

23C. NAME OF CEMETERY or CREMATORY

Mt Calvary Cemetery

23D. LOCATION

(City, town, or county)

A A County CoMd

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

APR 26 1967

Adolphus Halstead 1206 W porth Ave.

WALLEY & FORGE

WALLEY & FORGE

WALLEY & FORGE

WALLEY & FORGE

6E-1 FUNERAL DIRECTOR: IMPORTANT

SPARROW, BABY GIRL
DR. HEPNER

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|-----------|--|---------------------------------------|--|---|
| BIRTH NO. 67-07040 4109 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 4109 | |
| CERTIFICATE OF DEATH | | | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) SPARROW, Baby Girl | | | |
| 2. DATE AND HOUR OF DEATH | | 4/11/67 9:55 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE B. COUNTY | | | |
| UNIVERSITY | | Md | | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | BALTO. | | | |
| D. STREET ADDRESS (If rural, give location) | | 2106 W. HOLLINS ST | | | |
| 5. SEX F | 6. RACE N | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH 4/10/67 | 9. AGE (In years last birthday) | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
| | | | | BALTO | USA |
| 13. FATHER'S NAME JOHN SPARROW | | | 14. MOTHER'S MAIDEN NAME MARIE BUTLER | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS |
| | | | CHART | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH (A) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH | |
| PREMATURITY | | Prematurity | | Birth | |
| ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.) | | (B) DUE TO | | | |
| | | (C) DUE TO | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | Pneumonia RLL | | Birth | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 4/10 19 67 to 4/11 1967, that (I) (we) last saw the deceased alive on 4/11/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 4/11/67 | |
| 23C. PHYSICIAN'S NAME (Type) R. LUDDY | | 23D. ADDRESS | | | |
| | | M.D. ANATOMY BOTTLE HOUSE | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE 4-20-67 | | 24C. NAME OF CEMETERY or CREMATORY | |
| | | | | JOHNS HOPKINS MEDICAL SCHOOL | |
| 25A. DATE REC'D BY HEALTH DEPT. APR 26 1967 | | 25B. NAME OF REGISTRAR Robert E. Fisher | | 25C. FUNERAL DIRECTOR MORTUARY SERVICE - BCHD | |

10000

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|-------------------------|---|--|---|--|
| BIRTH NO.
M.E. CASE NO. | | BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | Registered No. <u>67 4110</u> | |
| 1. NAME OF DECEASED
(Type or Print) BABY BOY MC JILTON | | | 2. DATE AND HOUR OF DEATH
4. 11. 67. 10.30 A.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
UNION MEMORIAL HOSPITAL
44 | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND B. COUNTY BALTIMORE
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE
D. STREET ADDRESS (If rural, give location)
128 SOUTH EAST AVENUE | | |
| 5. SEX
MALE | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH
4. 10. 67 | 9. AGE (In years last birthday)
13 | If Under 1 Yr. Months: Days: Hours: Min.
55 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country)
MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. |
| 13. FATHER'S NAME
ROBERT MC JILTON | | | 14. MOTHER'S MAIDEN NAME
ESTHER LOUISE SNYDER | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS
[REDACTED] | | |
| 18. 773.51
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)
RESPIRATORY DISTRESS SYNDROME
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.
PREMATURITY. | | | CAUSE OF DEATH
(A) DUE TO
(B) DUE TO
(C) DUE TO | | |
| 19. DATE OF OPERATION
0 | | | 20. AUTOPSY? (Yes or No) | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that (I) (this hospital) attended the deceased from 4. 10. 1967 to 4. 11. 1967 and that (I) (we) last saw the deceased alive on 4. 11. 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
K. Shaw | | | 23B. DATE SIGNED
4/11/67 | | |
| 23C. PHYSICIAN'S NAME (Type)
K. SHAW | | | 23D. ADDRESS
UNION MEMORIAL HOSPITAL 330 E. BALTO, MD. | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE
4-18-67 | 24C. NAME OF CEMETERY or CREMATORY
JOHNS HOPKINS MEDICAL SCHOOL | | 24D. LOCATION (City, town, or county) (State)
BALTIMORE, MD. |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 26 1967 | | 25B. NAME OF REGISTRAR
Robert E. Taylor | | 25C. FUNERAL DIRECTOR
MORTUARY SERVICE - BCHD | |

DAY DAY THE JURY

UNION MEMORIAL HOSPITAL

WHITE WHITE

ROBERT W. JURY

STATIONER, BOSTON

STATIONER

125 SOUTH EAST AVENUE

4-10-07

STATIONER

STATIONER, BOSTON

STATIONER

STATIONER, BOSTON

STATIONER

4-11-07

4-11-07

X

UNION MEMORIAL HOSPITAL


K. JURY

K. JURY

4-10-07

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 4111 | |
|---|---------------------|---|--|---|---|
| BIRTH NO. 67 4111 | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) FREDERICK SANTMYER | | 2. DATE AND HOUR OF DEATH
5:25 AM 4/5/67 M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
University Hospital | | | 4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)
A. STATE MD
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE 4-01
D. STREET ADDRESS (If rural, give location)
424 E BALTIMORE | | |
| 5. SEX
M | 6. RACE
W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
Married | 8. DATE OF BIRTH
2-5-02 | 9. AGE (In years last birthday)
65 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
not known | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
not known | |
| 13. FATHER'S NAME
not known | | | 12. CITIZEN OF WHAT COUNTRY?
USA | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
unknown | | 16. SOCIAL SECURITY NO.
unknown | | 17. INFORMANT
Patient's record | |
| 18. 4-20-11
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)
(B) * Arteriosclerotic cardiovascular disease
ANTECEDENT CAUSES
(A) ** Acute myocardial infarction
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
(C) | | | INTERVAL BETWEEN ONSET AND DEATH
years
3-5 hours | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
yes no | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 2:30 AM 5 Apr 1967 to 5:25 AM 5 Apr 1967 , that (I) (we) last saw the deceased alive on 5 Apr 67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE

M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED
5 April 1967 | |
| 23C. PHYSICIAN'S NAME (Type)
KURT P SWIGART M.D. | | | | 23D. ADDRESS
University Hospital | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
4-20-67 | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY
JOHNS HOPKINS MEDICAL SCHOOL | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 26 1967 | | 25B. NAME OF REGISTRAR
R. E. E. E. E. | | 25C. FUNERAL DIRECTOR
MORTUARY SERVICE - BCHD | |

10/2/61

17-50-21

CERTIFICATE OF DEATH

Registered No.

67 4112

BIRTH NO.

67 4112

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

Alton East

2. DATE AND HOUR OF DEATH

4-4-67

1:00 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland 212244. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1613 St. Paul Street

21202

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Divorced

8. DATE OF BIRTH

11-2-1920

9. AGE (In years
last birthday)

46

If Under 1 Yr.
Months: Days:If Under 24 Hrs.
Hours: Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Alabama

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Walter

14. MOTHER'S MAIDEN NAME

Zora

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

Unknown

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Records: BCH-4940 Eastern Avenue 21224

18. 581.1 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Cirrhosis

1 year

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(B) DUE TO

Chronic Alcoholism

3 years

(C) DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (the hospital) attended the deceased from 4-1-1967 to 4-4-1967,
that (I) (we) last saw the deceased alive on 4-4-1967 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

23A. SIGNATURE

David J. Mischelevich

M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

4-4-67

23C. PHYSICIAN'S
NAME (Type)

David J. Mischelevich

23D. ADDRESS

M.O. 4940 Eastern Avenue, Baltimore, Md.

24A. BURIAL CREMATION,
REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION (City, town, or county) (State)

25A. DATE REC'D BY HEALTH DEPT.

APR 26 1967

25B. NAME OF REGISTRAR

Robert E. Taylor

25C. FUNERAL DIRECTOR

ADDRESS

JOHNS HOPKINS MEDICAL SCHOOL
MORTUARY SERVICE - BCHD

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

5005-10

BIRTH NO. 67 4113

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

67 4113

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

WILLIE JAMES MC CRAY

2. DATE AND HOUR PRONOUNCED DEAD

March 11, 1967 3:05 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

South Baltimore General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

117 W. Barre Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

9. AGE (In years
last birthday)

39

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Fatty Liver.
DUE TOANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B)
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT NOT WHILE
WORK AT WORK

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Petty

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3/12/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

23C. NAME of CEMETERY or CREMATORY

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

APR 26 1967

R. O. G. E. Farley

MORTUARY SERVICE - BCHD

19670004121

1944-45

1944-45

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

WILLIE L. JOHNSON

2. DATE AND HOUR PRONOUNCED DEAD

March 30, 1967 12:27 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

2239 Druid Hill Avenue

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2239 Druid Hill Avenue

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

9. AGE (In years
last birthday)

65

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Carbon Monoxide Intoxication.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Pulmonary Emphysema.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Home

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

2239 Druid Hill Avenue

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
3 30 '67 P

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

House fire.

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Petty

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3/30/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

4-17-67

23C. NAME OF CEMETERY or CREMATORY

23D. LOCATION (City, town, loc. county)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

APR 26 1967

Robert E. Farley, M.D.

MORTUARY SERVICE - BCHD

4-15-63

FUNERAL DIRECTOR: IMPORTANT

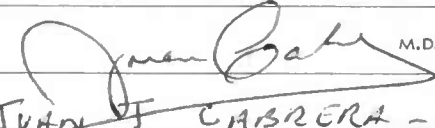
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|--------------|--|---|--|--|
| BIRTH NO. 67 4115 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 4115 | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED
(Type or Print) JOSEPH MLLS STOLL | | | 2. DATE AND HOUR OF DEATH
4-25-67 4 15 A.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
44
Univ Memorial Hosp | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE 2709 | | |
| | | | D. STREET ADDRESS (If rural, give location)
1409 NORTHGATE ROAD | | |
| 5. SEX
M | 6. RACE
W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
M | 8. DATE OF BIRTH
05-28-99 | 9. AGE (In years last birthday)
67 | 10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
REDA MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S. | | 13. FATHER'S NAME
CHARLES STOLL | | | |
| 14. MOTHER'S MAIDEN NAME | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)
527.11
Pulm. empty aema | | | CAUSE OF DEATH
(A) DUE TO
(B) DUE TO
(C) DUE TO | | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No. | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 04-23 1967 to 04-25 1967, that (I) (we) last saw the deceased alive on 04-24 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Zoltan Zarday | | | | 23B. DATE SIGNED
4-25-67 | |
| 23C. PHYSICIAN'S NAME (Type)
ZOLTAN ZARDAY, | | | | 23D. ADDRESS
THE UNION MEMORIAL HOSPITAL | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE
4-26-67 | | 24C. NAME OF CEMETERY or CREMATORY
UNIVERSITY MEDICAL SCHOOL | |
| 24D. LOCATION (City, town, or county) | | 24E. NAME OF REGISTRAR
APR 26 1967 | | 24F. FUNERAL DIRECTOR
MORTUARY SERVICE - BCHD | |

4-57-01

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | Registered No. 67 4116 | |
|---|-------------------------|--|--|--|--|--|--|---|---|-------------------------------|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| BIRTH NO. 67 4116 | | | | | | | | | | | |
| M.E. CASE NO. | | | | | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) GOBRECHT, NELSON S. | | | | | | 2. DATE AND HOUR OF DEATH
APRIL 24, 1967 3:00P M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND B. COUNTY HOWARD COUNTY | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
ST. AGNES HOSPITAL | | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
ELLICOTT CITY 63-00 | | | | | |
| | | | | | | D. STREET ADDRESS (If rural, give location)
112 GREENWAY DRIVE | | | | | |
| 5. SEX
MALE | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
MARRIED | | 8. DATE OF BIRTH
8/31/97 69 | | 9. AGE (In years last birthday) | | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
RETIRED | | | | 10B. KIND OF BUSINESS OR INDUSTRY
DEPT BALTO CITY POLICE | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | |
| 13. FATHER'S NAME
WILLIAM | | | | | | 14. MOTHER'S MAIDEN NAME
MARY STAYLOR | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)
NONE NONE | | | | 16. SOCIAL SECURITY NO.
216-28-9069 | | 17. INFORMANT ADDRESS
ST. AGNES HOSPITAL RECORDS 21229 | | | | | |
| 18. 4-20-1 I | | | | | | | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES | | | | | | CAUSE OF DEATH
(A) PNEUMONIA, RIGHT UPPER AND LOWER LOBES
DUE TO | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | (B) CHRONIC CONGESTIVE HEART FAILURE
DUE TO | | | | | |
| | | | | | | (C) ASCVD - PROBABLY MYOCARDIAL INFARCTION | | | | | |
| II | | | | | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from APRIL 24 19 67 to APRIL 24 19 67 , that (I) (we) last saw the deceased alive on APRIL 24 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE
 M.D. | | | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | 23B. DATE SIGNED
04-24-67 | | |
| 23C. PHYSICIAN'S NAME (Type)
JUAN J. CARRERA M.D. | | | | | | 23D. ADDRESS
21229 ST. AGNES HOSP; CATON & WILKENS AVES. | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
4/27/67 | | 24C. NAME OF CEMETERY or CREMATORY
Meadowridge Memorial | | | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 26 1967 | | | | 25B. NAME OF REGISTRAR
Robert E. Hubbard | | | | 25C. FUNERAL DIRECTOR ADDRESS
Howard H. Hubbard 4107 Wilkens Ave. | | | |

3:00

WILLIAM J. ...

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FUNERAL DIRECTOR: IMPORTANT

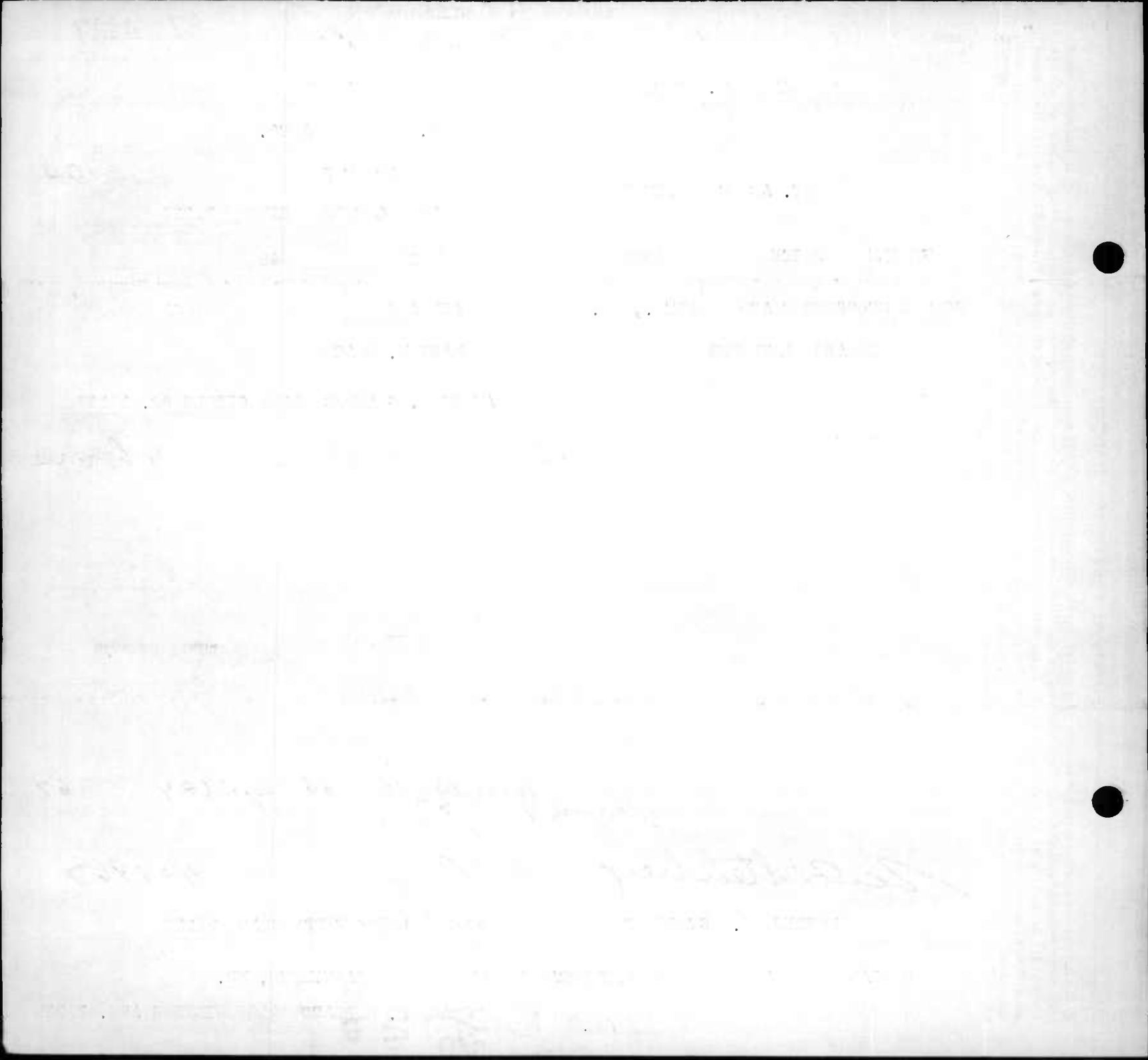
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Certificate of Death | | Registered No. 67 4117 | |
|---|---|--|--|--|--|--|--|
| BIRTH NO. 67 4117 | | | | | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) JANE M. MORAN | | | | 2. DATE AND HOUR OF DEATH
4/24/67 | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

40 ST. AGNES HOSPITAL | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE MD. B. COUNTY BALTO. Co. | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
ARBUTUS | | | |
| | | | | D. STREET ADDRESS (If rural, give location)
1231 CIRCLE DRIVE 21227 | | | |
| 5. SEX
FEMALE | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
MARRIED | | 8. DATE OF BIRTH
4/1/21 | 9. AGE (In years last birthday)
46 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
SCHOOL CROSSING GUARD | | 10B. KIND OF BUSINESS OR INDUSTRY
BALTO., CO. | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
EDWARD LAVENDER | | | | 14. MOTHER'S MAIDEN NAME
MARY M. ROACH | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
AGNES D. SHAFFER 1231 CIRCLE DR. 21227 | | | |
| 18. 4201 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osteonia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH
(A) Coronary occlusion
DUE TO
(B) _____
DUE TO
(C) _____ | | INTERVAL BETWEEN ONSET AND DEATH
4 hours | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION
O | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from November 19 1966 to April 24 1967 , that (I) (we) last saw the deceased alive on March 9 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
Morris W. Steinberg | | | | M.D. <input checked="" type="checkbox"/> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
4/25/67 | |
| 23C. PHYSICIAN'S NAME (Type)
MORRIS W. STEINBERG | | | | 23D. ADDRESS
M.D. 3913 HOLLINS FERRY ROAD 21227 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
4/28/67 | | 24C. NAME OF CEMETERY or CREMATORY
NEW CATHEDRAL CEMETERY | | 24D. LOCATION (City, town, or county) (State)
BALTIMORE, MD. | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 26 1967 | | 25B. NAME OF REGISTRAR
Robert E. Johnson | | 25C. FUNERAL DIRECTOR
HOWARD H. HUBBARD | | ADDRESS
4107 WILKENS AVE. 21229 | |

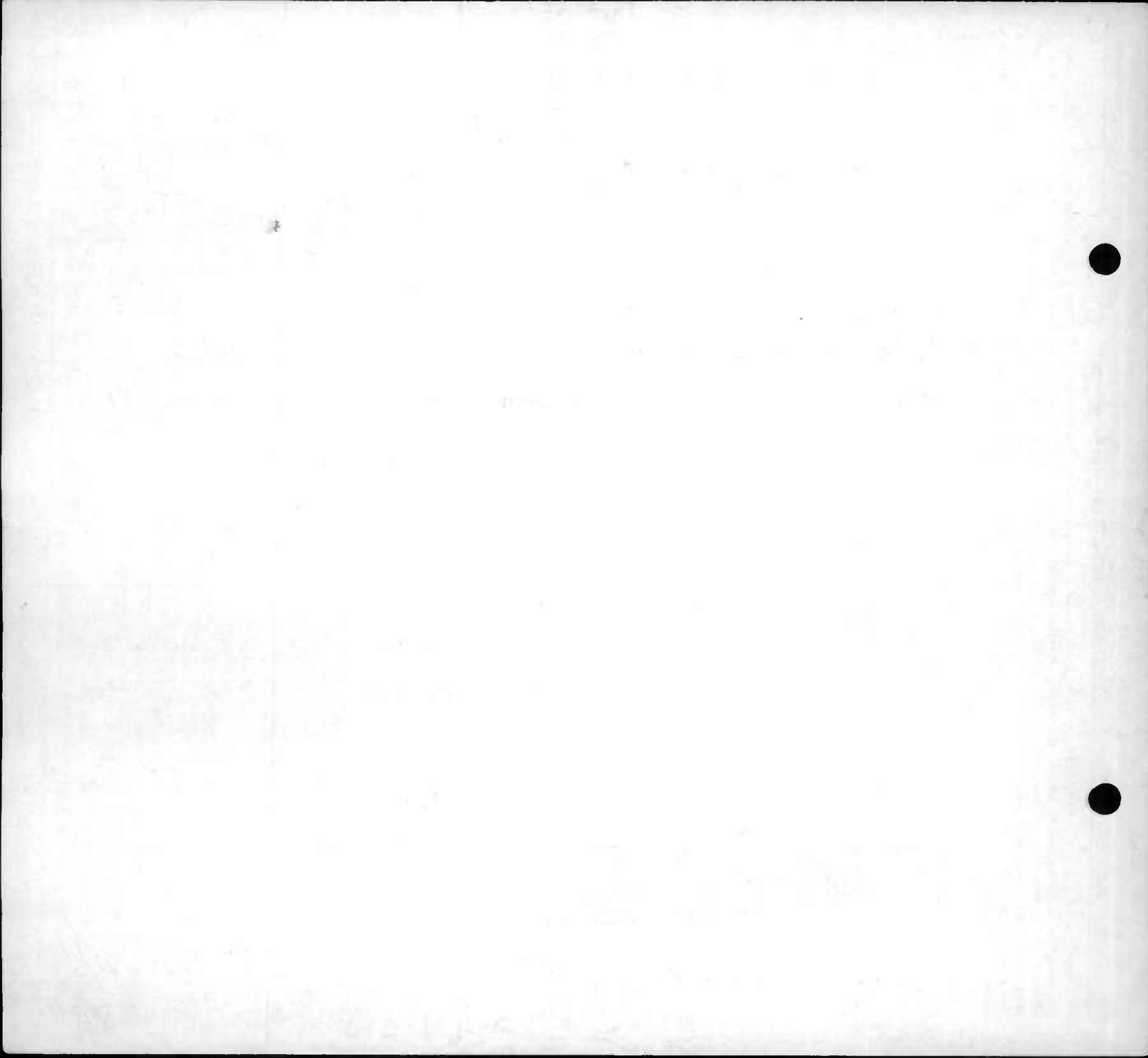


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|--|--|---|--|--|--|---|---|--|
| CERTIFICATE OF DEATH | | | | | Registered No. 67 4118 | | | | |
| BIRTH NO. 67 4118 | | | | | M.E. CASE NO. | | | | |
| 1. NAME OF DECEASED
(Type or Print) Vienna Mrs Mary | | | | | 2. DATE AND HOUR OF DEATH
4/25/67 at 11:45 A.M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location)
35 Church Home and Hospital | | | | | A. STATE MD | | | | |
| | | | | | B. COUNTY St. Regester | | | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | | | | | D. STREET ADDRESS (If rural, give location)
237 REGESTER STREET | | | | |
| | | | | | E. CITY OR TOWN (If outside city limits, write RURAL and give township)
31 - Md 2-02 | | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED
TWIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH
12-8-96 | 9. AGE (In years last birthday)
70 | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSE WIFE | | 10B. KIND OF BUSINESS OR INDUSTRY
AT HOME | | 11. BIRTHPLACE (State or foreign country)
ITALY | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | |
| 13. FATHER'S NAME
LEONARD CASTINO | | | | | 14. MOTHER'S MAIDEN NAME
CONCETTA UNK. | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | | | 16. SOCIAL SECURITY NO.
214-26-81464 | | 17. INFORMANT
THOMAS VIENNA | | |
| 18. 260X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | | | | CAUSE OF DEATH
(A) Coronary Heart Disease
DUE TO
(B) A.S.C.U.D.
DUE TO
(C) Diabetes Mellitus | | | INTERVAL BETWEEN ONSET AND DEATH
ESSEX 21 MO. | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION
0 | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 4-15-1967 to 4-25-1967 , that (I) (we) lost saw the deceased alive on 4-25-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
Rodelio M. Lim M.D. | | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | 23B. DATE SIGNED
4-25-67 | |
| 23C. PHYSICIAN'S NAME (Type)
Rodelio M. Lim M.D. | | | | | 23D. ADDRESS
Church Home & Hosp. | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
4-29-67 | | 24C. NAME OF CEMETERY or CREMATORY
HOLY REDEEMER CEM | | 24D. LOCATION (City, town, or county) (State)
BEAIR RD BALTO MD. | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 26 1967 | | 25B. NAME OF REGISTRAR
R. E. ... | | 25C. FUNERAL DIRECTOR
DIAPER Bros. | | ADDRESS
1800 E. Lombard St. 21231 | | | |



43-09-73 1G6

67 4119

CERTIFICATE OF DEATH

Registered No. 67 4119

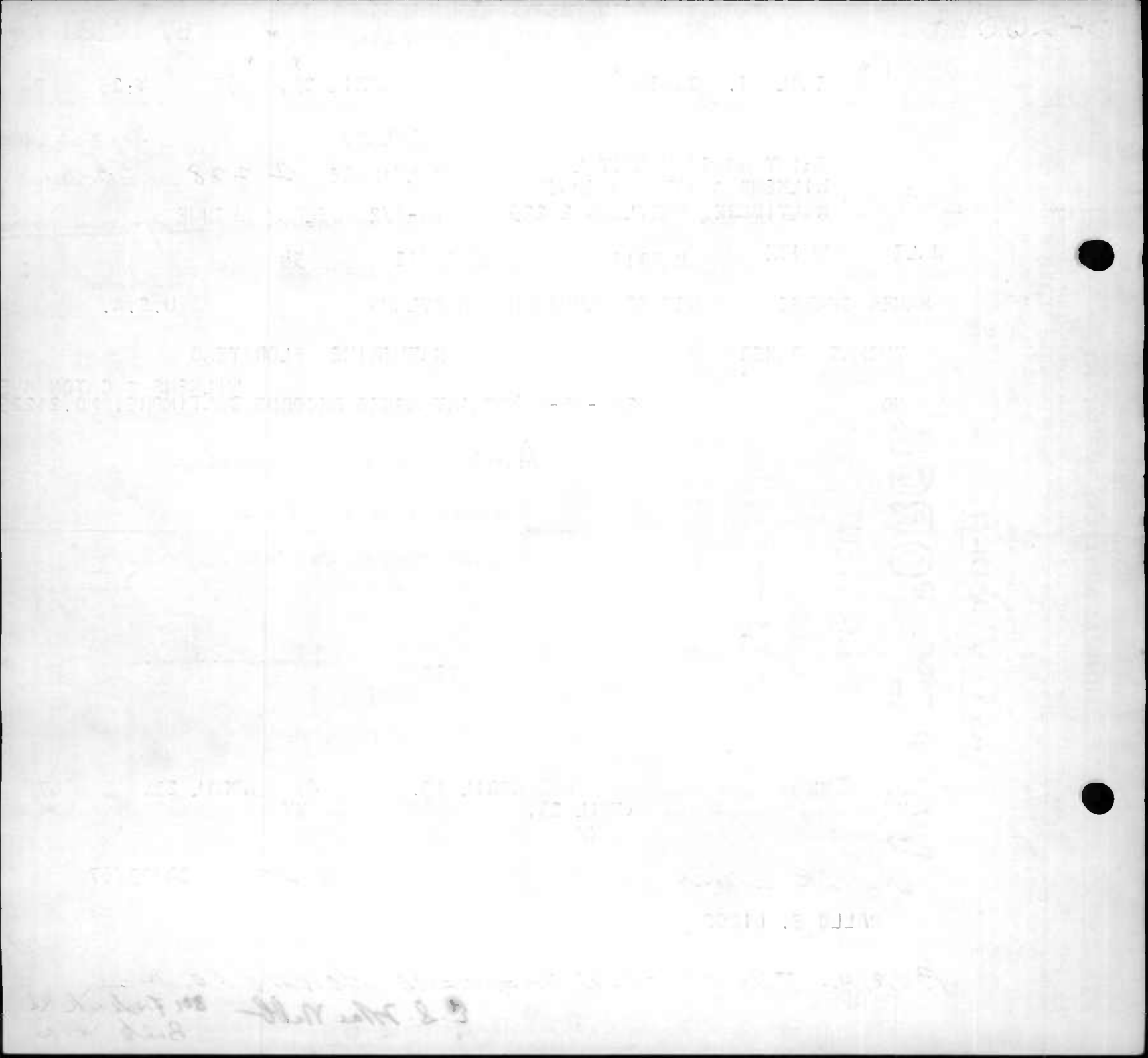
| | | | |
|--|---------------|---|--------------------------|
| BIRTH NO. 67 4119 | | BALTIMORE CITY HEALTH DEPT. | |
| M.E. CASE NO. | | 2. DATE AND HOUR OF DEATH (Month/Day/Year) 4/24/67 7:20 P.M. | |
| 1. NAME OF DECEASED (Type or Print) Clyde A. Thompson | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND B. COUNTY 23-01 | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
31 BALTIMORE CITY HOSPITALS
4940 EASTERN AVENUE
BALTIMORE 21224, MARYLAND | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE
D. STREET ADDRESS (If rural, give location) 8 W. CROSS STREET #21230 | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) DIVORCED | 8. DATE OF BIRTH 12-9-09 |
| 9. AGE (In years last birthday) 57 (57) | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gen'l. Laborer | |
| 11. BIRTHPLACE (State or foreign country) VIRGINIA | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME CHARLES C. Thompson | | 14. MOTHER'S MAIDEN NAME MARGARET PORTER PORTIS | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. (236-09-2675) | |
| 17. INFORMANT (Name and address of person furnishing information) Mrs. Helena A. Porter (same) | | RECORDS: BCH 4940 EASTERN AVENUE #21224 | |
| 18. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
CVA
ASCVD | | INTERVAL BETWEEN ONSET AND DEATH
2 yrs
10 yrs | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 12/8 19 66 to 4/24 19 67, that (I) (we) last saw the deceased alive on 4/24 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE William A. Emerson M.D. | | 23B. DATE SIGNED 4/24/67 | |
| 23C. PHYSICIAN'S NAME (Type) Dr. William A. Emerson | | 23D. ADDRESS Baltimore City Hospitals 4940 Eastern Ave. #21224 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 4/27/67 | |
| 24C. NAME OF CEMETERY OR CREMATORY Glen Haven | | 24D. LOCATION (City, town, or county) (State) Glen Burnie Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. APR 27 1967 | | 25B. NAME OF REGISTRAR Curtis E. Evans | |
| 25C. FUNERAL DIRECTOR ADDRESS 14005 CHARLES ST BALTO MD 21230 | | | |

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>67 4120</u> | |
|--|-------------------------|---|--|---|--|
| BIRTH NO. <u>67 4120</u> | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | | | 2. DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED
(Type or Print) <u>EARL E. BAKER</u> | | | | <u>APRIL 23, 1967</u> <u>4:25</u> P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>40 SAINT AGNES HOSPITAL</u>
<u>WILKENS & CATON AVENUES</u>
<u>BALTIMORE, MARYLAND 21229</u> | | | | A. STATE <u>MARYLAND</u>
B. COUNTY <u>Balts Co</u> | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>BALTIMORE</u> <u>21228</u> <u>53-00</u> | |
| | | | | D. STREET ADDRESS (If rural, give location)
<u>14-1/2 DELRAY AVENUE</u> | |
| 5. SEX
<u>MALE</u> | 6. RACE
<u>WHITE</u> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<u>MARRIED</u> | 8. DATE OF BIRTH
<u>09/05/12</u> | 9. AGE (In years last birthday)
<u>54</u> | If Under 1 Yr. Months: Days: Hours: Min.
If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>MAKER CHARGE</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>KEYSER ALUMINUM</u> | 11. BIRTHPLACE (State or foreign country)
<u>MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> |
| 13. FATHER'S NAME
<u>THOMAS BAKER</u> | | | 14. MOTHER'S MAIDEN NAME
<u>KATHERINE FLORSTEAD</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>NO</u> | | 16. SOCIAL SECURITY NO.
<u>215-03-8741</u> | 17. INFORMANT ADDRESS
<u>WILKENS & CATON AVE</u>
<u>BALTIMORE, MD. 21229</u> | | |
| 18. <u>420.1 I</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
<u>Acute myocardial infarction.</u>
<u>Coronary thrombosis.</u>
<u>Adrenal nodes - bilateral.</u> | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
<u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<u>YES</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that <u>XX</u> (this hospital) attended the deceased from <u>APRIL 19,</u> 19 <u>67</u> to <u>APRIL 23,</u> 19 <u>67</u> , that <u>XIX</u> (we) last saw the deceased alive on <u>APRIL 23,</u> 19 <u>67</u> and that in <u>XX</u> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <u>XX</u> (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>Pallo E. Dibos</u> | | | | 23B. DATE SIGNED
<u>04/23/67</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>PALLO E. DIBOS</u> | | | | 23D. ADDRESS
M.D. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | 24B. DATE
<u>4/26/67</u> | | 24C. NAME of CEMETERY or CREMATORY
<u>GODD SHEPHERD</u> | |
| 24D. LOCATION
<u>HOWARD CO. MD.</u> | | 25A. DATE RECEIVED BY HEALTH DEPT.
<u>APR 27 1967</u> | | 25B. NAME OF REGISTRAR
<u>Robert E. Stachura</u> | |
| 25C. FUNERAL DIRECTOR
<u>G. S. Nabb</u> | | 25D. ADDRESS
<u>301 Frederick Rd</u>
<u>Bethesda</u> | | | |



Handwritten signature and scribbles at the bottom of the page.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | | | Registered No. 67 4121 | |
|---|-------------------------|--|---|--|---|
| BIRTH NO. 67 4121 | | M.E. CASE NO. | | | |
| 1. NAME OF DECEASED
(Type or Print) HARTMAN, Ethel | | | 2. DATE AND HOUR OF DEATH
4-23-67 2 15 P.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
North Charles General | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD.
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
412 S. EAST AVE. #21224 | | |
| 5. SEX
Female | 6. RACE
Cauc. | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH
7-9-97 | 9. AGE (In years last birthday)
69 YRS. | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY?
United States | | | 13. FATHER'S NAME
William Conn | | |
| 14. MOTHER'S MARDEN NAME
Ida Lynch | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | |
| 16. SOCIAL SECURITY NO.
214-03-4460 | | | 17. INFORMANT ADDRESS
North Charles General Hospital | | |
| 18. 175.0 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)
CAUSE OF DEATH
(A) PULmonary Edema
DUE TO
(B) Metastatic Adenocarcinoma
DUE TO
(C) of the ovary (P) | | | | | |
| II
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 4/22/67 19 to 4/23 1967, that (I) (we) last saw the deceased alive on 4/22 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Mrs. Jewell | | | | 23B. DATE SIGNED
23 April 1967 | |
| 23C. PHYSICIAN'S NAME (Type)
DR. Highstein | | | | 23D. ADDRESS
M.D. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
4-26-67 | | 24C. NAME OF CEMETERY OR CREMATORY
Gardens of Faith | |
| 24D. LOCATION
MD. | | 25A. DATE REC'D BY HEALTH DEPT.
APR 27 1967 | | | |
| 25B. NAME OF REGISTRAR
Robert E. Forbush | | 25C. FUNERAL DIRECTOR
Thelma A. Hoffmann | | ADDRESS
3218 N. Linden St. | |

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|-----------|--|--|--|---|
| BIRTH NO. 67 4122 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 4122 | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED
(Type or Print) MILLER, GOLDIE C. | | | 2. DATE AND HOUR OF DEATH
4/25/67 6:45 A.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
42 SINAI HOSPITAL | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A, STATE MD. B, COUNTY BALTIMORE
C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 27-20
D. STREET ADDRESS (If rural, give location) 2504 STEELE RD. #9 | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED | 8. DATE OF BIRTH 9/1/29 | 9. AGE (In years last birthday) 87 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY At Home | | 11. BIRTHPLACE (State or foreign country) VIRGINIA | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 13. FATHER'S NAME Joseph H. Dodd | | |
| 14. MOTHER'S MAIDEN NAME Lucy Dowell | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | |
| 16. SOCIAL SECURITY NO. 214-24-2635 | | | 17. INFORMANT ADDRESS Mrs. Gladys M. Patterson 2504 Steele Rd. | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
420.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | CAUSE OF DEATH
(A) DUE TO Myocardial Infarct - 15 days ago
(B) DUE TO ASCVD
(C) | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from 4/10/19 67 to 4/25/19 67, that (I) (we) last saw the deceased alive on 4/25/19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | 23A. SIGNATURE Hyman Greenfield M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> 23B. DATE SIGNED 4/25/67 | |
| 23C. PHYSICIAN'S NAME (Type) HYMAN GREENFIELD M.D. | | 23D. ADDRESS SINAI HOSPITAL | | 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | |
| 24B. DATE 4-28-1967 | | 24C. NAME OF CEMETERY or CREMATORY Lorraine Park | | 24D. LOCATION Woodlawn, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. APR 27 1967 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR G. Howard Strong 3207 W. North Ave., | |

2

100

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | Registered No. 67 4123 | |
|---|--|-----------------------------|--|--|--|--|--|--|--|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| BIRTH NO. 67 4123 | | M.E. CASE NO. | | | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) Miss Ellen Cannady | | | | | | 2. DATE AND HOUR OF DEATH
April 25, 1967 11:35A. M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
44 Union Memorial Hospital | | | | | | A. STATE
md | | | | | |
| | | | | | | B. COUNTY | | | | | |
| | | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | | | | | |
| | | | | | | D. STREET ADDRESS (If rural, give location)
5306 York Road | | | | | |
| 5. SEX
Female | | 6. RACE
Caucasian | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> (Specify) | | 8. DATE OF BIRTH
11/11/16 | | 9. AGE (In years last birthday)
50 | | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Telephone operator | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
N. Carolina | | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Roberson Cannady | | | | | | 14. MOTHER'S MAIDEN NAME
Annie Jane Holland | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | | 16. SOCIAL SECURITY NO.
211-20-2223 | | 17. INFORMANT
Mrs Edna Wilkerson | | | | ADDRESS
609 Anneshe Rd. | |
| 18. 331 X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | CAUSE OF DEATH
(A) Cerebro-vascular accident
DUE TO
(B) _____
DUE TO
(C) _____ | | | | INTERVAL BETWEEN ONSET AND DEATH
8d | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | |
| 19A. DATE OF OPERATION
0 | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20A. AUTOPSY? (Yes or No)
No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (he) (this hospital) attended the deceased from 4/19 19 67 to 4/25 19 67 , that (I) (we) last saw the deceased alive on 4/25 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE
Nat E. Watson, Jr. | | | | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
4/25/67 | |
| 23C. PHYSICIAN'S NAME (Type)
NAT E. WATSON, JR. | | | | | | 23D. ADDRESS
M.D. THE UNION MEMORIAL HOSPITAL | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
4/27/67 | | 24C. NAME of CEMETERY or CREMATORY
Harrell's Cemetery | | | | 24D. LOCATION (City, town, or county) (State)
Harrells North Carolina | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | | | 25B. NAME OF REGISTRAR
R. E. E. Jackson | | | | 25C. FUNERAL DIRECTOR
Royal-Hall Funeral Home Clinton, | | | |
| | | | | | | | | ADDRESS
North Carolina | | | |

Miss Ellen Connolly

April 20, 1927

Union Memorial Hospital
2300 York Road
Baltimore

Female Gonorrhea

Telephone operator
Robertson Connolly

Mr. John Holland
Mr. John W. Keiser

Cardio-vascular accident

No

Not a patient

AT 2:15 PM

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. | |
|---|-------------------------|---|---|---|---|
| BIRTH NO.
67 4124 | | CERTIFICATE OF DEATH | | 67 4124 | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED
(Type or Print) ROBERT E. LEA | | | 2. DATE AND HOUR OF DEATH
4-25-1967 2.10 A.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

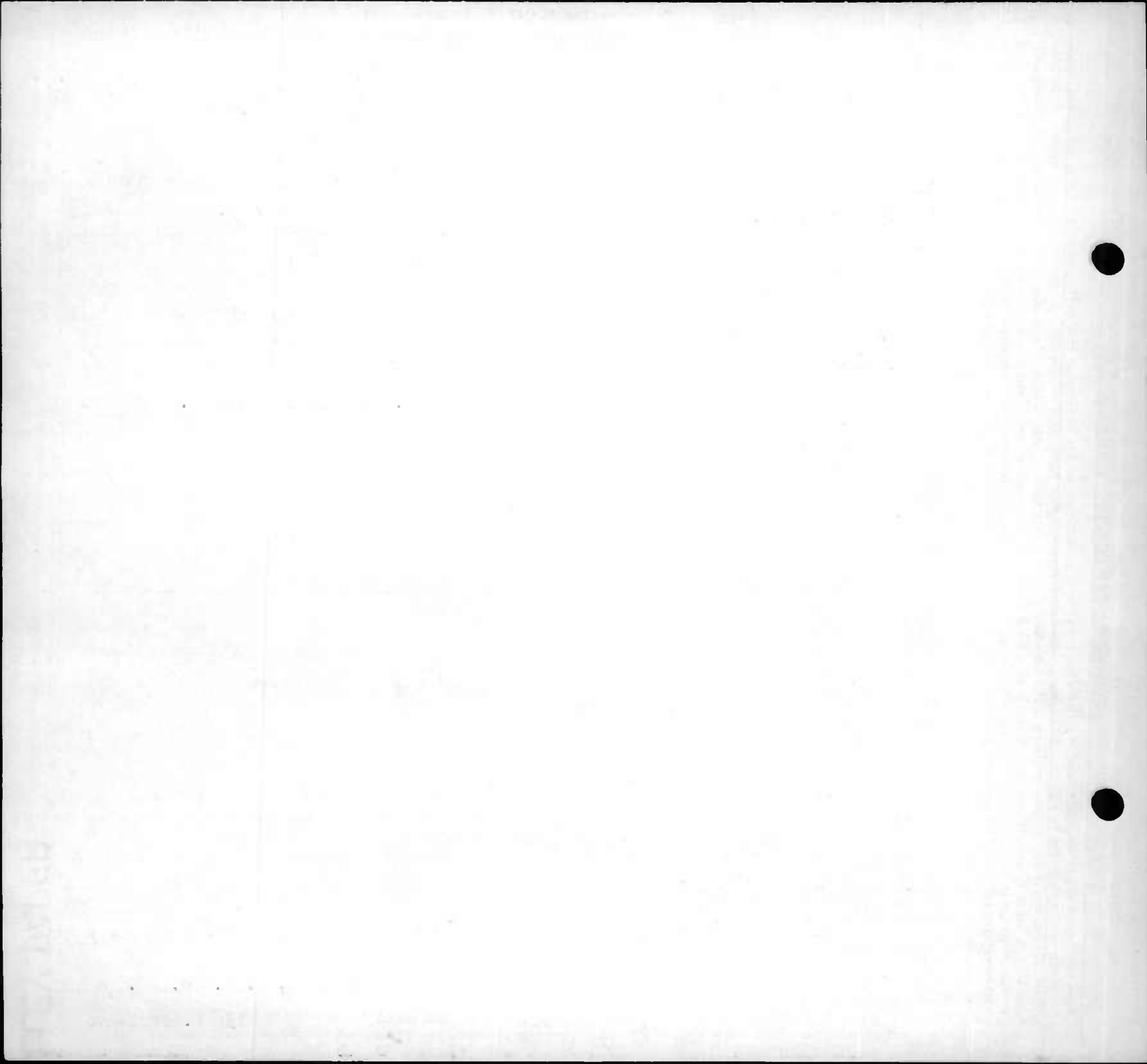
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
NORTH CHARLES GEN. HOSP. | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE
D. STREET ADDRESS (If rural, give location) 5022 E. OLIVER ST. | | |
| 5. SEX
Male | 6. RACE
White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
MARRIED | 8. DATE OF BIRTH
10-10-1888 | 9. AGE (In years last birthday)
78 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired | | 10B. KIND OF BUSINESS OR INDUSTRY
DAVIDSON CHEM. CO. | 11. BIRTHPLACE (State or foreign country)
Va. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. |
| 13. FATHER'S NAME
ALFRED LEA | | | 14. MOTHER'S MAIDEN NAME
MARY | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
Yes WWI | | 16. SOCIAL SECURITY NO.
223-10-5998A | 17. INFORMANT ADDRESS
NORTH CHARLES GEN. HOSP. CHART. | | |
| 18. 527.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
CHRONIC PULMONARY EMPHYSEMA 15 years
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
A.S.C.V.D. 20 years | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from 4-10-1967 to 4-25-1967 , that (1) (we) last saw the deceased alive on 4-25-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Joane F. Oleman M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED
4-25-1967 | |
| 23C. PHYSICIAN'S NAME (Type)
CORAL GORDON M.D. | | | 23D. ADDRESS
611 PARK AVE. BALTIMORE MD. | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
4/28/67 | | 24C. NAME OF CEMETERY or CREMATORY
Meadowridge Memorial Park Cem. | |
| 24D. LOCATION
Dorsey, Maryland | | 25A. DATE REC'D BY HEALTH DEPT.
APR 27 1967 | | | |
| 25B. NAME OF REGISTRAR
Robert E. Farley | | 25C. FUNERAL DIRECTOR ADDRESS
John J. Duda, 7922 Wise Ave. Dundalk, Md. | | | |

10

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

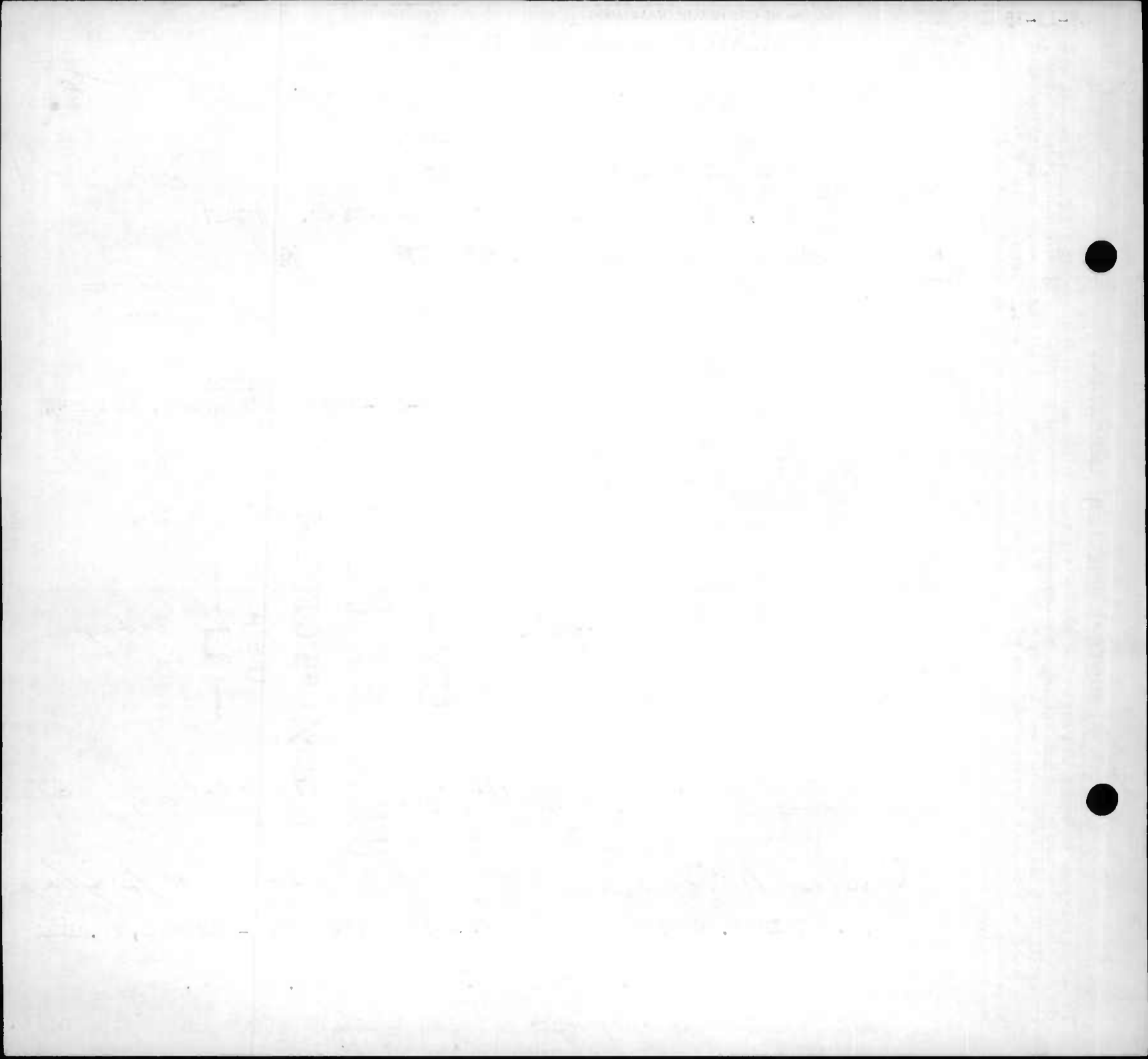
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 4125 | |
|--|-------------------------|--|---|--|--|
| BIRTH NO. 67 4125 | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | | 2. DATE AND HOUR OF DEATH | | |
| 1. NAME OF DECEASED
(Type or Print) <i>Evelyn M. Cramblitt</i> | | | 4-26-67 11:00 A.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived; If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<i>43 South Baltimore General Hosp.</i>
(If not in hospital or institution, give street address or location) | | | A. STATE <i>Maryland</i> | | |
| | | | B. COUNTY | | |
| | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | |
| | | | <i>Baltimore</i> #2123-24-02 | | |
| | | | D. STREET ADDRESS (If rural, give location) | | |
| | | | <i>408 E. Fort Ave.</i> | | |
| 5. SEX
<i>F</i> | 6. RACE
<i>White</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
<i>Married</i> | 8. DATE OF BIRTH
<i>12-28-1904</i> | 9. AGE (In years last birthday)
<i>62</i> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>None</i> | | 10B. KIND OF BUSINESS OR INDUSTRY
<i>Housewife</i> | 11. BIRTHPLACE (State or foreign country)
<i>Baltimore, Md.</i> | | 12. CITIZEN OF WHAT COUNTRY?
<i>U S A</i> |
| 13. FATHER'S NAME
<i>John Herring</i> | | | 14. MOTHER'S MAIDEN NAME
<i>Sophie Bory</i> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>No</i> | | 16. SOCIAL SECURITY NO. | 17. INFORMANT
<i>Robert C. Cramblitt</i> | | ADDRESS
<i>408 E. Fort Ave</i> |
| 18. <i>260X I</i>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH
(A) <i>Dissecta mellitus</i>
DUE TO
(B) <i>Arteriosclerotic cardiovascular disease</i>
DUE TO
(C) | | INTERVAL BETWEEN ONSET AND DEATH
<i>50 years</i>
<i>10 years</i> |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
<i>2</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<i>YES.</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that the (this hospital) attended the deceased from <i>4-20</i> 19 <i>67</i> to <i>4-26</i> 19 <i>67</i> , that the (we) last saw the deceased alive on <i>4-26</i> 19 <i>67</i> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<i>Gary A. Fleming</i> | | | | 23B. DATE SIGNED
<i>4-26-67</i> | |
| 23C. PHYSICIAN'S NAME (Type)
<i>Gary A. Fleming</i> | | | | 23D. ADDRESS
<i>South Baltimore General Hosp.</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 24B. DATE
<i>4 29 67</i> | | 24C. NAME OF CEMETERY or CREMATORY
<i>Cedar Hill</i> | |
| 24D. LOCATION (City, town, or county) (State)
<i>Brooklyn, A. A. Co. Md.</i> | | 25A. DATE REC'D BY HEALTH DEPT.
<i>APR 27 1967</i> | | | |
| 25B. NAME OF REGISTRAR
<i>Paul E. Fairman</i> | | 25C. FUNERAL DIRECTOR
<i>Mc Cully</i> | | ADDRESS
<i>130 E. Fort Ave</i> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| 49-13-26 [B] C-552 67 4126 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 4126 | |
|---|-----------------------------|--|-----------------------------------|---|--|
| BIRTH NO. | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) <u>James Cummings</u> | | 2. DATE AND HOUR OF DEATH
<u>4/24/67</u> <u>8:50</u> P. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE <u>MARYLAND</u>
B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>31 BALTIMORE CITY HOSPITALS</u>
<u>4940 EASTERN AVENUE</u>
<u>BALTIMORE, MARYLAND 21224</u> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>BALTIMORE</u> | | | |
| | | D. STREET ADDRESS (If rural, give location)
<u>1834 LAWRENCE ST. #21217</u> | | | |
| 5. SEX
<u>MALE</u> | 6. RACE
<u>NEGRO</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
<u>SEPARATED married</u> | 8. DATE OF BIRTH
<u>4-1-07</u> | 9. AGE (In years lost birth)
<u>60</u> | If Under 1 Yr. Months Days Hours Min.
If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>GEORGIA</u> | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME
<u>Sally Howard</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
<u>239189155</u> | | 17. INFORMANT
<u>#21224</u>
<u>RECORDS-BCH-4940 EASTERN AVENUE, BALTIMORE</u> | |
| 18. <u>603X I</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)
<u>Uremia</u> | | (A) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH
<u>? 6 mo</u> | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO
<u>Obstructive uropathy</u> | | (C) DUE TO
<u>? 2 yr.</u> | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
<u>Sepsis</u> | | | | <u>3 days?</u> | |
| 19A. DATE OF OPERATION
<u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<u>NO</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>4/22</u> 19 <u>67</u> to <u>4/24</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4/24</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>William A. Emerson</u> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
<u>4/24/67</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>DR. WILLIAM A. EMERSON</u> | | 23D. ADDRESS
M.D. <u>BCH-4940 EASTERN AVENUE-BALTIMORE, MD. 21224</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | 24B. DATE
<u>4-28-67</u> | 24C. NAME of CEMETERY or CREMATORY
<u>Mt. Auburn Cem.</u> | | 24D. LOCATION (City, town, or county) (State)
<u>Balto. Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>APR 27 1967</u> | | 25B. NAME OF REGISTRAR
<u>Robert E. Taylor</u> | | 25C. FUNERAL DIRECTOR
<u>Kelson Funeral Home 1348 Calhoun St.</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|------------------|--|--|---------------------------------------|--|--|--|--|--|
| CERTIFICATE OF DEATH | | | | | Registered No. 67 4127 | | | | |
| BIRTH NO. 67 4127 | | | | | M.E. CASE NO. | | | | |
| 1. NAME OF DECEASED
(Type or Print) Mrs Lemma Wilson Wallace | | | | | 2. DATE AND HOUR OF DEATH
April 23, 1967 12:55A.M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE B. COUNTY | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Union Memorial Hospital | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location)
2783 The Alameda | | | | |
| 5. SEX
Female | 6. RACE
Negro | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH
4/20/23 | 9. AGE (In years last birthday)
44 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | | 10B. KIND OF BUSINESS OR INDUSTRY
Homemaking | | 11. BIRTHPLACE (State or foreign country)
Virginia | | 12. CITIZEN OF WHAT COUNTRY?
USA | | |
| 13. FATHER'S NAME
Henry Parker | | | 14. MOTHER'S MAIDEN NAME
Susan | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | 16. SOCIAL SECURITY NO.
579-22-1937 | | 17. INFORMANT
Mrs Ruby Watson 3316 Mondawmin Ave Baltimore Md. | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
Carcinoma of Colon | | | | | INTERVAL BETWEEN ONSET AND DEATH
8 mos | | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | | | |
| II | | | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examined) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While Af Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (1) (this hospital) attended the deceased from 4/22 19 67 to 4/23 1967, that (1) (we) lost saw the deceased alive on 4/23 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
Nate E. Watson, Jr. | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
4/23/67 | | |
| 23C. PHYSICIAN'S NAME (Type)
DR NAT E. WATSON JR | | | | | 23D. ADDRESS
THE UNION MEMORIAL HOSPITAL | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | | 24B. DATE
4/26/67 | | 24C. NAME of CEMETERY or CREMATORY
Mt Auburn | | 24D. LOCATION (City, town, or county) (State)
Baltimore | | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 27 1967 | | | 25B. NAME OF REGISTRAR
J. A. E. Watson | | 25C. FUNERAL DIRECTOR
Thomas P. Anger 635 N. Gilmor | | | | |

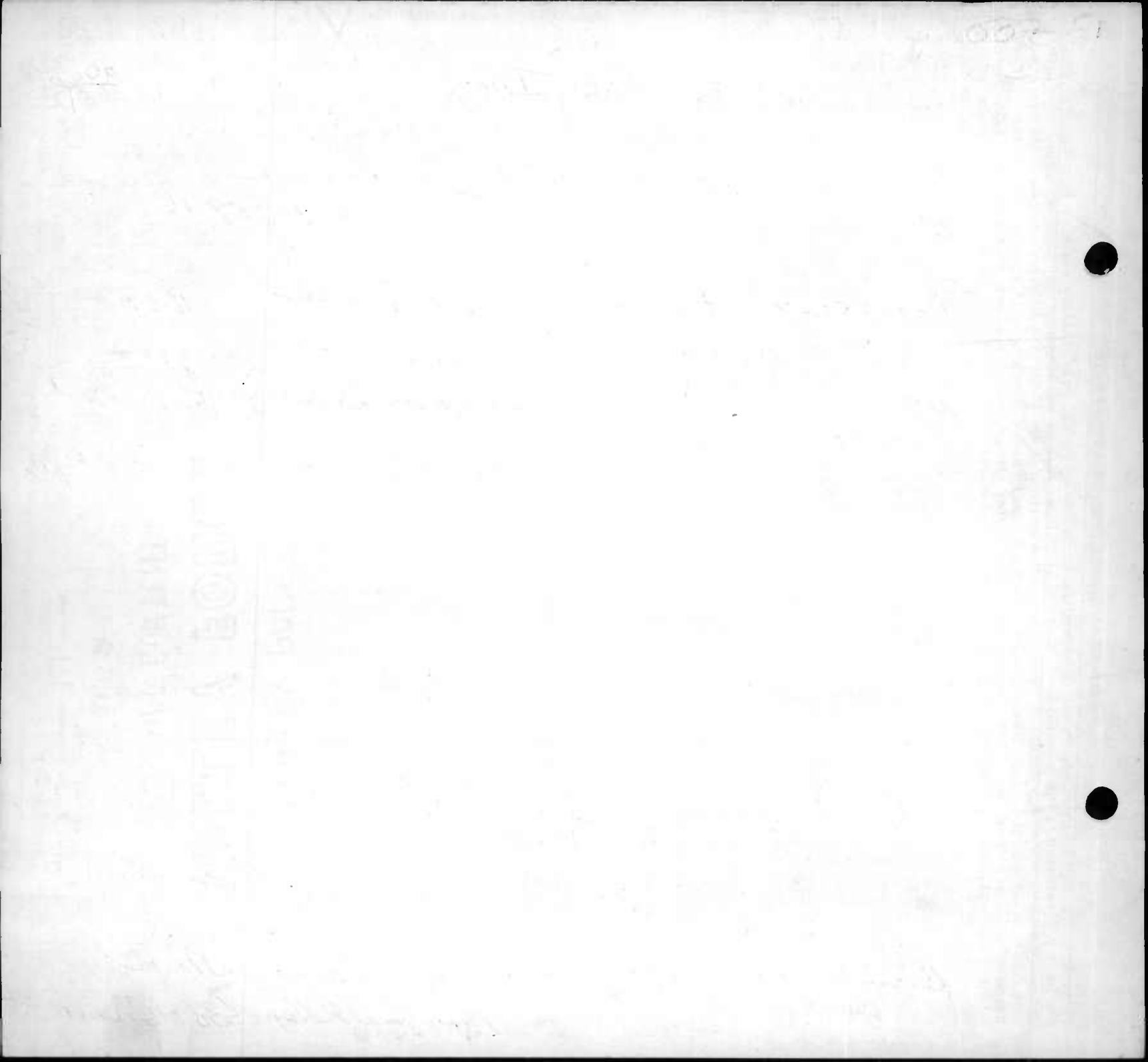
Government of Colorado
The Capital at Denver
and the State of Colorado

Henry Barker
Housewife
Frank Rogers
Union Memorial Hospital
Denver
April 23
44

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|---------|---|--|--|---|--|------------------------------|----------------------------------|--|
| 67 4128 | | | | | Registered No. 67 4128 | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| BIRTH NO. | | M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| | | | | BOONE, MARY INEZ | | 4/24/67 11:00 | | M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location) | | | | | A. STATE B. COUNTY | | | | |
| 33 Johns Hopkins Hospital | | | | | Maryland 9.9 Co. | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | | |
| | | | | | Pasadena 52-00 | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location) | | | | |
| | | | | | Rt. 11-Box 459 D. | | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH | 9. AGE (In years lost birthday) | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | |
| Female | Negro | Married | | 12/23/25 | 41 | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | | |
| Domestic | | | Put Family | | Charles Co. Md | | USA | | |
| 13. FATHER'S NAME | | | | | 14. MOTHER'S MAIDEN NAME | | | | |
| Howard Brown | | | | | Bessie Briscoe | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | | ADDRESS | |
| no | | | | | Benjamin Boone Jr. Pasadena Md | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | | | | CAUSE OF DEATH | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 180X I | | | | | Hypernephroma | | | 3 1/2 yrs | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | (A) DUE TO | | | | |
| | | | | | (B) DUE TO | | | | |
| | | | | | (C) DUE TO | | | | |
| II | | | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 2 | | | | Yes | | no | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| | | | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | | | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | | | |
| 22. I certify that (1) (this hospital) attended the deceased from 4/23/67 to 4/24/67, that (1) (we) last saw the deceased alive on 4/24/67, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE | | | | | 23B. DATE SIGNED | | | | |
| Sherrard Hayes M.D. | | | | | 4/24/67 | | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | | 23D. ADDRESS | | | | |
| Sherrard Hayes M.D. | | | | | Johns Hopkins Hospital | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY | | 24D. LOCATION (City, town, or county) (State) | | | |
| Burial | | 4/4/67 | | Mt Zion Church | | Pasadena Md | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | | | |
| APR 27 1967 | | Benjamin Boone Jr. | | Sherrard Hayes | | 638 N 61st St | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REGISTERED No. | |
|--|-------------------------|---|---|--|---|
| BIRTH NO. 67 4129 | | CERTIFICATE OF DEATH | | 67 4129 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) CIULLA, JESSE S. | | 2. DATE AND HOUR OF DEATH
4/21/67 9:00 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
SINAI HOSPITAL OF BALT., INC. | | A. STATE MARYLAND B. COUNTY Baltimore Co. | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE 21204 53-00 | | | |
| | | D. STREET ADDRESS (If rural, give location)
620 FAIRWAY DR. | | | |
| 5. SEX
M | 6. RACE
White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
Married | 8. DATE OF BIRTH
12/23/11 | 9. AGE (In years last birthday)
55 | 10. If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Barber | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
ITALY | |
| 13. FATHER'S NAME
Joseph Ciulla | | | 12. CITIZEN OF WHAT COUNTRY?
USA | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | 16. SOCIAL SECURITY NO.
216-03-1597 | | 17. INFORMANT ADDRESS
Mrs. Dorothy M. Ciulla (Same) |
| 18. I | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) DUE TO
ACUTE MYOCARDIAL INFARCTION | | 1 wk. | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO
ARTERIOSCLEROTIC CARDIOVASCULAR DIS | | YRS. | |
| | | (C) | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
None | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
None | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED
White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (this hospital) attended the deceased from 4/14 19 67 to 4/21 19 67 , that (I) did last saw the deceased alive on 4/21 19 67 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) did (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
G. Brett Lazar | | | | 23B. DATE SIGNED
4/21/67 | |
| 23C. PHYSICIAN'S NAME (Type)
J. Brett Lazar | | | | 23D. ADDRESS
SINAI HOSP OF BALT., INC. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
4/26/67. | | 24C. NAME OF CEMETERY or CREMATORY
Gardens of Faith Cemetery | |
| | | | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 27 1967 | | 25B. NAME OF REGISTRAR
Robert E. Feltz | | 25C. FUNERAL DIRECTOR ADDRESS
Leonard J. Ruck, Inc. Balto. Md. 21214 | |

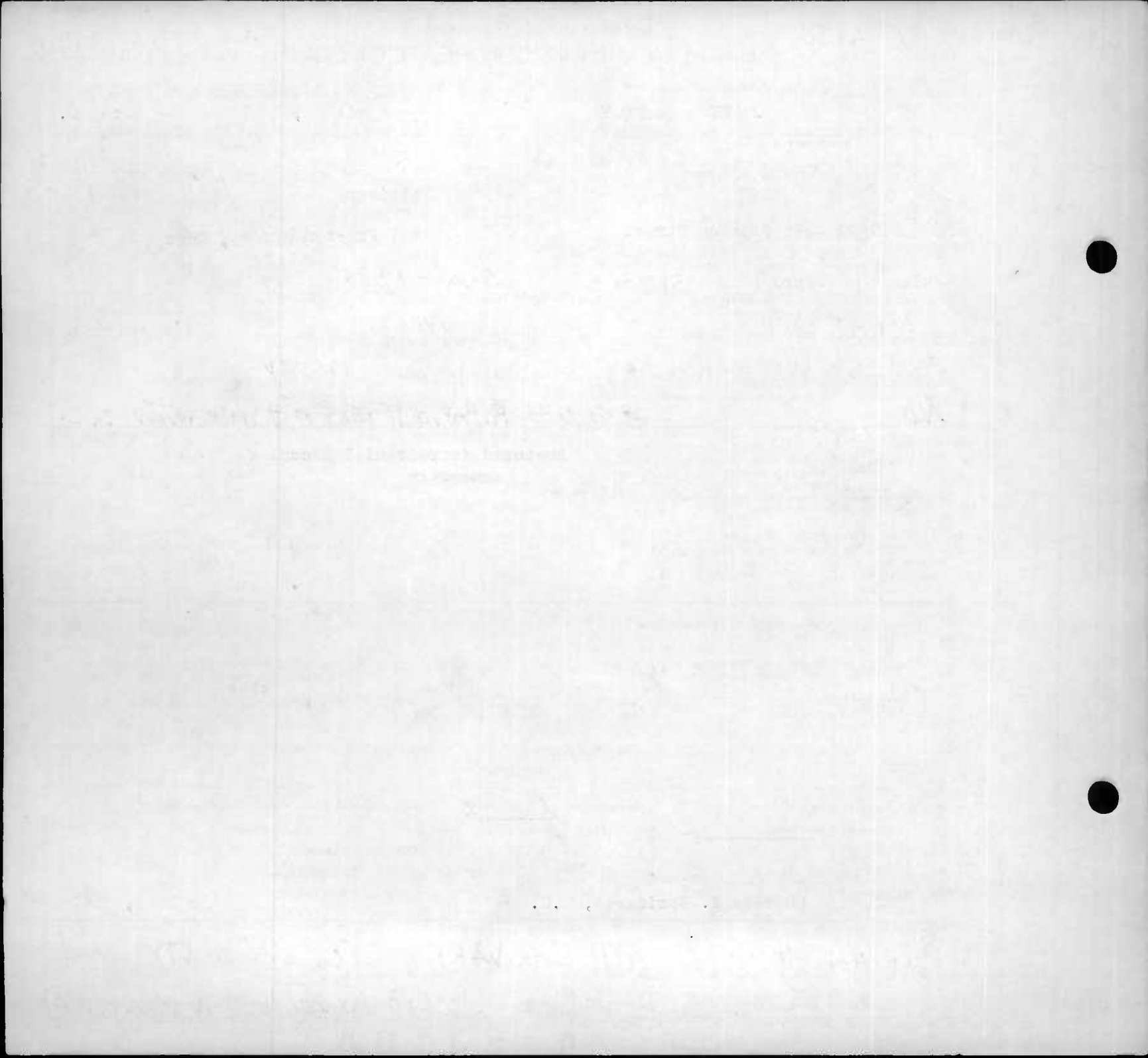
1
B-653

67 4130
BIRTH NO. MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 4130

| | | | | | |
|---|--|---|--|---|--|
| 1. NAME OF DECEASED
(Type or Print) | | JAMES BARNETT | | 2. DATE AND HOUR PRONOUNCED DEAD
April 22, 1967 2:45 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION

00 1431 East Preston Street | | A. STATE
Maryland
B. COUNTY
Baltimore 10-61 | | | |
| 5. SEX
Male | | 6. RACE
Negro | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
SINGLE | |
| 8. DATE OF BIRTH
5-28-1938 | | 9. AGE (In years last birthday)
29 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
MEAT CUTTER | |
| 11. BIRTHPLACE (State or foreign country)
N.C. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
JAMES W. BARNETT | |
| 14. MOTHER'S MAIDEN NAME
RIVERS Woody | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
241-54-4233 | |
| 17. INFORMANT
R. BARNETT 1505-17th St. WASHINGTON D.C. | | 18. CAUSE OF DEATH
Ruptured intracranial saccular aneurysm | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) DUE TO | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (B) DUE TO | | | |
| (C) DUE TO | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
Yes | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE
Charles S. Springate | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED
April 23, 1967 | |
| EXAMINER'S NAME (Type)
Charles S. Springate, M.D. | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| 23A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 23B. DATE
4-28-67 | | 23C. NAME OF CEMETERY or CREMATORY
MT CALVARY | |
| 23D. LOCATION
A.A. COUNTY md | | 24A. DATE REC'D BY HEALTH DEPT.
APR 27 1967 | | 24B. NAME OF REGISTRAR
Robert E. Farkas | |
| 24C. FUNERAL DIRECTOR
JOSEPH KNIGHT 1639 N BROADWAY | | 24D. ADDRESS | | | |

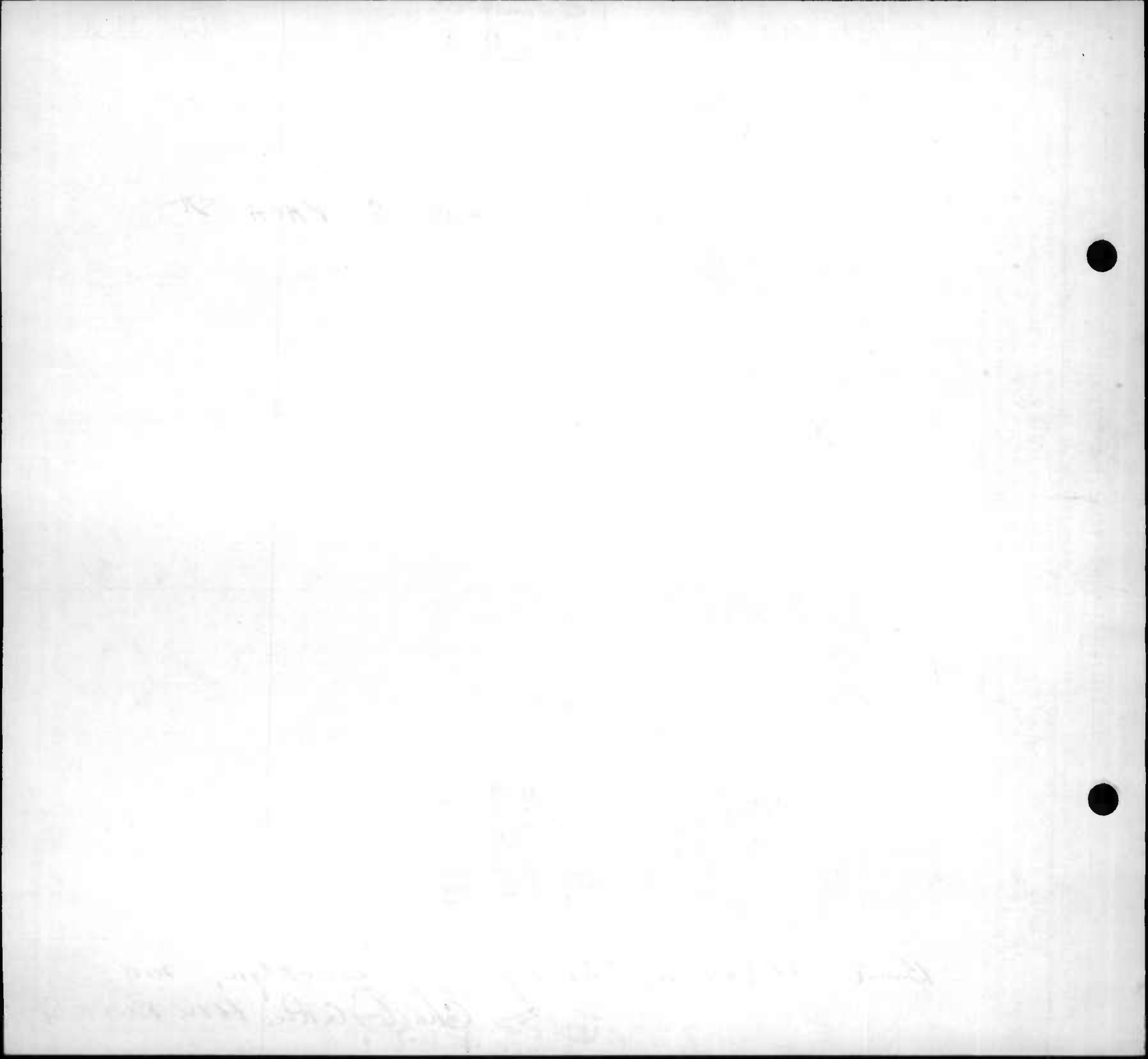
19670004130



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>67 4131</u> | |
|---|-----------------------|---|--|--|---|
| BIRTH NO. <u>67 4131</u> | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) <u>EMMA MERCER</u> | | 2. DATE AND HOUR OF DEATH
<u>25 April 67 10 02 A.M.</u> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>38 UNIV. OF MD.</u> | | | A. STATE <u>MD.</u>
B. COUNTY _____ | | |
| (If not in hospital or institution, give street address or location) | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>DALTON</u> | | |
| | | | D. STREET ADDRESS (If rural, give location)
<u>634 S. PACA ST.</u> | | |
| 5. SEX
<u>F</u> | 6. RACE
<u>Neg</u> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<u>WIDOW</u> | 8. DATE OF BIRTH
<u>7/16/05</u> | 9. AGE (In years last birthday)
<u>61</u> | If Under 1 Yr. Months: _____ Days: _____ If Under 24 Hrs. Hours: _____ Min. _____ |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country)
<u>N. Carolina</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> |
| 13. FATHER'S NAME
<u>THOMAS LAWRENCE</u> | | | 14. MOTHER'S MAIDEN NAME
<u>MARY HARRIS</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
<u>?</u> | 17. INFORMANT
<u>Chant -</u> | | |
| | | ADDRESS | | | |
| 18. <u>443X I</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
<u>INTRACRANIAL HEMORR</u> | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH
<u>< 48 hrs</u> |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (A) DUE TO | | (B) DUE TO |
| | | | (C) DUE TO | | years ? |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
<u>24 Apr</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
<u>Hemorrhage diagnosis</u> | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>23 Apr</u> 19 <u>67</u> to <u>25 Apr</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>25 Apr</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>Stanley Music</u> | | | | 23B. DATE SIGNED
<u>25 Apr 67</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>STANLEY MUSIC</u> | | | | 23D. ADDRESS
<u>90 UNIV HOSP</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>4/29/67</u> | | 24C. NAME of CEMETERY or CREMATORY
<u>mt Calvary</u> | |
| 24D. LOCATION (City, town, or county) (State)
<u>Brooklyn, md</u> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>APR 27 1967</u> | | 25B. NAME OF REGISTRAR
<u>Charles A Rice</u> | | 25C. FUNERAL DIRECTOR ADDRESS
<u>661 W. Barre St</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 67 4132 | |
|--|------------|---|----------------------------------|--|--|
| CERTIFICATE OF DEATH | | | | Registered No. | |
| BIRTH NO. 67 4132 | | | | | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED
(Type or Print) ARTHUR W. HARRIS | | 2. DATE AND HOUR OF DEATH
4/26/67 1 ¹⁵ a. M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
NORTH CHARLES GENERAL HOSPITAL
49 | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY 27-05
C. CITY OR TOWN BALTIMORE
D. STREET ADDRESS (If rural, give location)
3911 Pinewood AVE. 21206 | | | |
| 5. SEX M. | 6. RACE W. | 7. (MARRIED, NEVER MARRIED, WIDOWED, DIVORCED) (specify) WIDOWED | 8. DATE OF BIRTH
APR 3 / 1897 | 9. AGE (In years last birthday) 69 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
retired CARPENTER | | 10B. KIND OF BUSINESS OR INDUSTRY
CONSTRUCTION | | 11. BIRTHPLACE (State or foreign country)
Md. CARROLL COUNTY | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | |
| 13. FATHER'S NAME
William Harris | | 14. MOTHER'S MAIDEN NAME
IDA ? YINGLING | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
217-07-8172A | | 17. INFORMANT
N. CHARLES Gen. Hosp.
ROBERT L. HARRIS 3913 PINEWOOD AVE | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ACUTE MYOCARDIAL INFARCT
DUE TO
BRONCHOPNEUMONIA
CORONARY ARTERY DIS. OCCASION
PULMONARY EMPHYSEMA OLD | | INTERVAL BETWEEN ONSET AND DEATH
recent | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 3/19 1967 to 4/26/ 1967, that (I) (we) last saw the deceased alive on 4/26 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Robert Roubenoff M.O. | | | | 23B. DATE SIGNED
4/26/67 | |
| 23C. PHYSICIAN'S NAME (Type)
ROBERT ROUBENOFF M.O. | | | | 23D. ADDRESS
N. CHARLES Gen. Hosp. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
APR 29 1967 | | 24C. NAME OF CEMETERY OR CREMATORY
LORRAINE PARK CEM. | |
| 24D. LOCATION
5608 DOGWOOD RD MD | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 27 1967 | | 25B. NAME OF REGISTRAR
Robert E. Taylor | | 25C. FUNERAL DIRECTOR
DIPPEL BRAS INC 7110 BELAIR ROAD | |

2000-2001

2000-2001

2000-2001

2000-2001

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 4133 | |
|--|----------------------|--|------------------------------------|--|---|
| CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. 67 4133 | | | | | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED
(Type or Print) Marjorie Baker Isaac | | 2. DATE AND HOUR OF DEATH
4-26-67 5:00 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Baltimore Co. | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
44 Union Memorial Hospital | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Towson 53-00 | | | |
| D. STREET ADDRESS (If rural, give location)
910 Delancy Valley Court | | | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married | 8. DATE OF BIRTH
4-14-97 | 9. AGE (In years last birthday) 69 | 10. CITIZEN OF WHAT COUNTRY
USA |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Illinois | |
| 13. FATHER'S NAME
John Albert Baker | | 14. MOTHER'S MAIDEN NAME
Elizabeth Parker | | 12. CITIZEN OF WHAT COUNTRY
USA | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No None | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
Rev. F. Reid Isaac (Same) | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)
Generalized Carcinomatosis with Intestinal Obstruction | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) DUE TO | | (B) DUE TO | |
| | | (C) DUE TO | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At <input type="checkbox"/> Work | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 4-9-1967 to 4-26-1967 , that (I) (we) last saw the deceased alive on 4-26-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Miriam A. Cohen | | | | 23B. DATE SIGNED
4-26-67 | |
| 23C. PHYSICIAN'S NAME (Type)
MIRIAM A. COHEN, | | | | 23D. ADDRESS
THE UNION MEMORIAL HOSPITAL | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
4/28/1967 | | 24C. NAME OF CEMETERY or CREMATORY
Mt. Olivet Cemetery | |
| 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 27 1967 | | 25B. NAME OF REGISTRAR
Robert E. Stalder | | 25C. FUNERAL DIRECTOR
Wm. J. Johnson & Sons | |
| | | | | ADDRESS
Baltimore, Md. North Pa. | |

The above is a list of the names of the persons who have been admitted to the membership of the Society since the last meeting. The names are given in the order in which they were admitted.

BIRTH NO. **67 4134** MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. **67 4134**

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)**WILLIAM L. DIEFENBACH**

2. DATE AND HOUR PRONOUNCED DEAD

4-25-67**3:55 PM**

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)**MARYLAND GENERAL HOSPITAL**4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE**Maryland**

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

719 M⁴ Holly Street 21229

5. SEX

Male

6. RACE

White7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)**Married**

8. DATE OF BIRTH

Dec. 19, 18859. AGE (In years
last birthday)**81**10. Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)**Retired**

10B. KIND OF BUSINESS OR INDUSTRY

Beth. Steel

11. BIRTHPLACE (State or foreign country)

Maryland12. CITIZEN OF
WHAT COUNTRY?**USA**

13. FATHER'S NAME

John Diefenbach

14. MOTHER'S MAIDEN NAME

Elizabeth ---15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.17. INFORMANT ADDRESS
**Mrs. William L. Diefenbach
17 Hunter Drive - Belair, Md.**18. **E 812.41**

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) **Bronchopneumonia complicating**
fracture of right femur

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) **fracture of right femur**
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.**Arteriosclerotic cardiovascular disease**

19A. DATE OF OPERATION

219B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?**Yes**21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)**Street**21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)**Howard and Saratoga Streets**21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
2 6 '67 11:00

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

**Subject was walking
across Saratoga at Howard Street When
struck by truck**

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒
and that on this basis, death in my opinionresulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)**RUSSELL S. FISHER, M.D.**CHIEF MEDICAL EXAMINER ☒M.D. ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4-26-6723A. BURIAL CREMATION,
REMOVAL (Specify)**Burial**

23B. DATE

4-28-67

23C. NAME OF CEMETERY or CREMATORY

Loudon Park Cem.

23D. LOCATION

(City, town, or county)

Baltimore, Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

APR 27 1967

24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

Witzke F. D. - 4101 Edmondson Ave.

ADDRESS

Dec. 19, 1933

Received

Myland

East Steel

Received

Mr. William L. DeLamater
14 Hunter Drive - New York, N.Y.

John DeLamater

Baltimore, Md.

London Park Co.

4-38-37

Initial

Wicks V. B. - 4411 Broadway Ave.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 4135 | |
|---|-------------------------|---|---|--|--|
| BIRTH NO. 67 4135 | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | | 2. DATE AND HOUR OF DEATH | | |
| 1. NAME OF DECEASED
(Type or Print) <i>Virginia R. KANE</i> | | | April 25, 1967 5:00 P.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<i>Union Memorial Hospital</i>
<i>44</i> | | | A. STATE
<i>MARYLAND</i> | | |
| (If not in hospital or institution, give street address or location) | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<i>BALTIMORE</i> | | |
| | | | D. STREET ADDRESS (If rural, give location)
<i>1641 BURNWOOD RD.</i> | | |
| 5. SEX
<i>FEMALE</i> | 6. RACE
<i>WHITE</i> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<i>MARRIED</i> | 8. DATE OF BIRTH
<i>11-18-29</i> | 9. AGE (In years last birthday)
<i>37</i> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>HOUSEWIFE</i> | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<i>MARYLAND</i> |
| 12. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | | 13. FATHER'S NAME
<i>MISH XXXX Cobb</i> | | |
| 14. MOTHER'S MAIDEN NAME
<i>ALMA Brock XXXXXX</i> | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>No</i> | | |
| 16. SOCIAL SECURITY NO.
<i>247386927</i> | | | 17. INFORMANT
<i>MR. CARENCE J. KANE</i>
<i>HUSBAND</i> | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
<i>Cirrhosis of the Liver</i> | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<i>No</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>April 12</i> 1967 to <i>April 25</i> 1967 that (I) (we) last saw the deceased alive on <i>April 25</i> 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<i>James W. Carty, Jr.</i> | | | | 23B. DATE SIGNED
<i>4/25/67</i> | |
| 23C. PHYSICIAN'S NAME (Type)
<i>JAMES W. CARTY MD.</i> | | | | 23D. ADDRESS
<i>THE UNION MEMORIAL HOSPITAL</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 24B. DATE
<i>4/28/67</i> | | 24C. NAME OF CEMETERY or CREMATORY
<i>Moreland Cemetery</i> | |
| 24D. LOCATION (City, town or county) (State)
<i>Baltimore, Maryland</i> | | 25A. DATE REC'D BY HEALTH DEPT.
<i>APR 27 1967</i> | | | |
| 25B. NAME OF REGISTRAR
<i>Robert E. Taylor</i> | | 25C. FUNERAL DIRECTOR
<i>Leonard J. Ruck Inc. 5305 Harford Rd.</i> | | | |

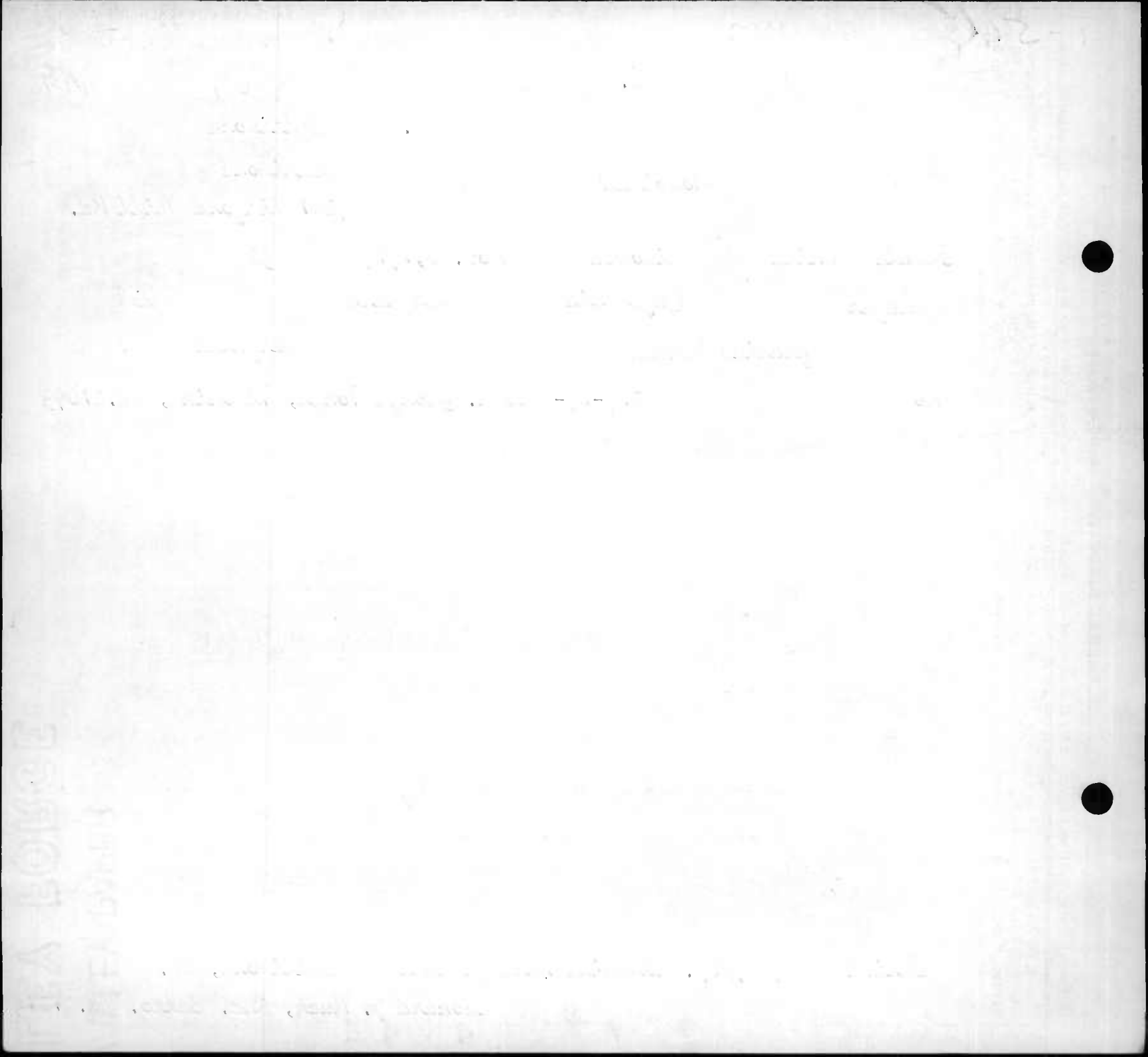
City of the
River

THE CITY OF THE RIVER

THE CITY OF THE RIVER

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | X | | Registered No. | |
|--|--|---|--|--|--|---|--|
| BIRTH NO. 67 4136 | | CERTIFICATE OF DEATH | | 67 4136 | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) <i>MARGARET B. TONER</i> | | 2. DATE AND HOUR OF DEATH
<i>4-25-67 11:15 P.M.</i> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <i>Md.</i> B. COUNTY <i>Baltimore Co.</i> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<i>Baltimore</i> | | D. STREET ADDRESS (If rural, give location)
<i>4201 Milford Mill Rd.</i> | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<i>37 Mercy Hospital</i> | | 5. SEX <i>Female</i> 6. RACE <i>White</i> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Widowed</i> | | 8. DATE OF BIRTH <i>Nov. 6, 1914</i> 9. AGE (In years last birthday) <i>52</i> | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Manager</i> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY <i>Cafeteria</i> | | 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 13. FATHER'S NAME <i>Ignatius Neuman</i> | | 14. MOTHER'S MAIDEN NAME <i>Margaret ?</i> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>214-14-0208</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <i>Mr. George Toner, Timonium, Md.</i> | | ADDRESS <i>21093</i> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
<i>260X I</i>
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
<i>II</i>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
<i>Acute Myocardial Infarction</i> | | CAUSE OF DEATH
(A) DUE TO <i>(R) Cerebrovascular Accident</i>
(B) DUE TO <i>—</i>
(C) <i>Diabetes Mellitus</i> | | INTERVAL BETWEEN ONSET AND DEATH
<i>10 hrs.</i> | | | |
| 19A. DATE OF OPERATION <i>2</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>Yes</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>No</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>4-13</i> 19 <i>67</i> to <i>4-25</i> 19 <i>67</i> , that (I) was lost saw the deceased alive on <i>4-25</i> 19 <i>67</i> and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) We (did) did not view the body after death. | | 23A. SIGNATURE <i>Michael A. Ellis</i> M.D. | | 23B. DATE SIGNED <i>4-25-67</i> | | | |
| 23A. SIGNATURE | | 23B. DATE SIGNED | | 23C. PHYSICIAN'S NAME (Type) <i>Michael A. Ellis</i> M.D. | | 23D. ADDRESS <i>Mercy Hosp 4/25/67</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>4/29/67</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>Lorraine Park Cemetery</i> | | 24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>APR 27 1967</i> | | 25B. NAME OF REGISTRAR <i>Leonard J. Ruck, Inc.</i> | | 25C. FUNERAL DIRECTOR <i>Leonard J. Ruck, Inc.</i> | | ADDRESS <i>Balto. Md. 21214</i> | |



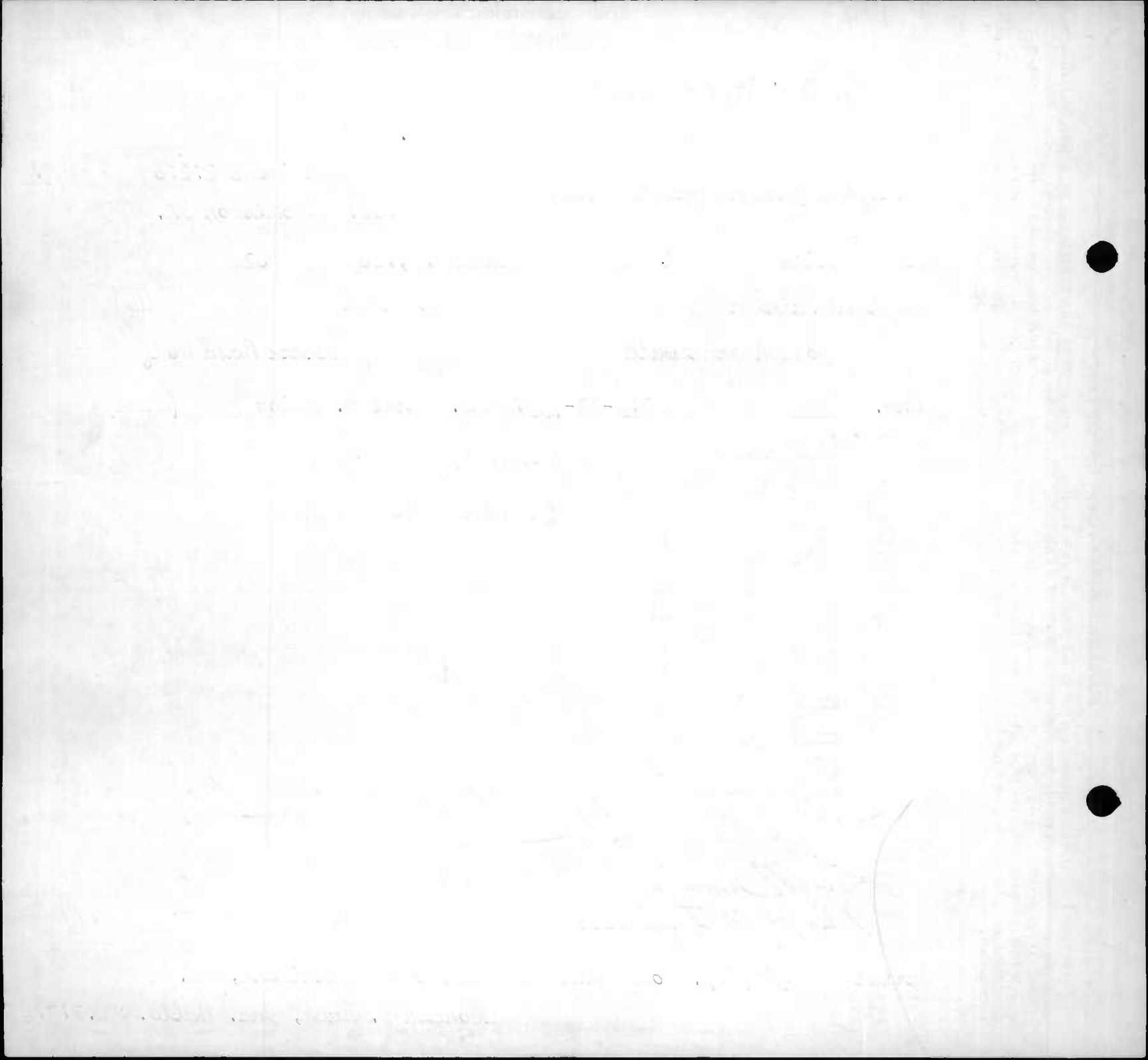
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 4137 | |
|---|---|---|--|--|--|
| <div style="display: flex; justify-content: space-between;"> BIRTH NO. 67 4137 CERTIFICATE OF DEATH </div> | | | | | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED
(Type or Print) PIUS E. SAUERWALD | | | 2. DATE AND HOUR OF DEATH
Apr. 26 1967 5:30 A. M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
90 Harford Gardens Nursing Home | | | A. STATE Md.
B. COUNTY | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | |
| | | | Baltimore 21218 9-07 | | |
| | | | D. STREET ADDRESS (If rural, give location) | | |
| | | | 1601 Abbottston St. | | |
| 5. SEX
Male | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Single | 8. DATE OF BIRTH
March 13, 1885 | 9. AGE (In years last birthday)
82 | If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired Painter | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA |
| 13. FATHER'S NAME
Joseph Sauerwald | | | 14. MOTHER'S MAIDEN NAME
xxxxx Rosa Wolf | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
Unk. | | 16. SOCIAL SECURITY NO.
215-22-9331 | 17. INFORMANT
Mrs. Agnes B. Seipp | | ADDRESS
(Same) |
| 18. 331X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH
(A) Cerebral Vascular Accident
DUE TO
(B) Cerebral Arteriosclerosis
DUE TO
(C) | | INTERVAL BETWEEN ONSET AND DEATH
6 weeks

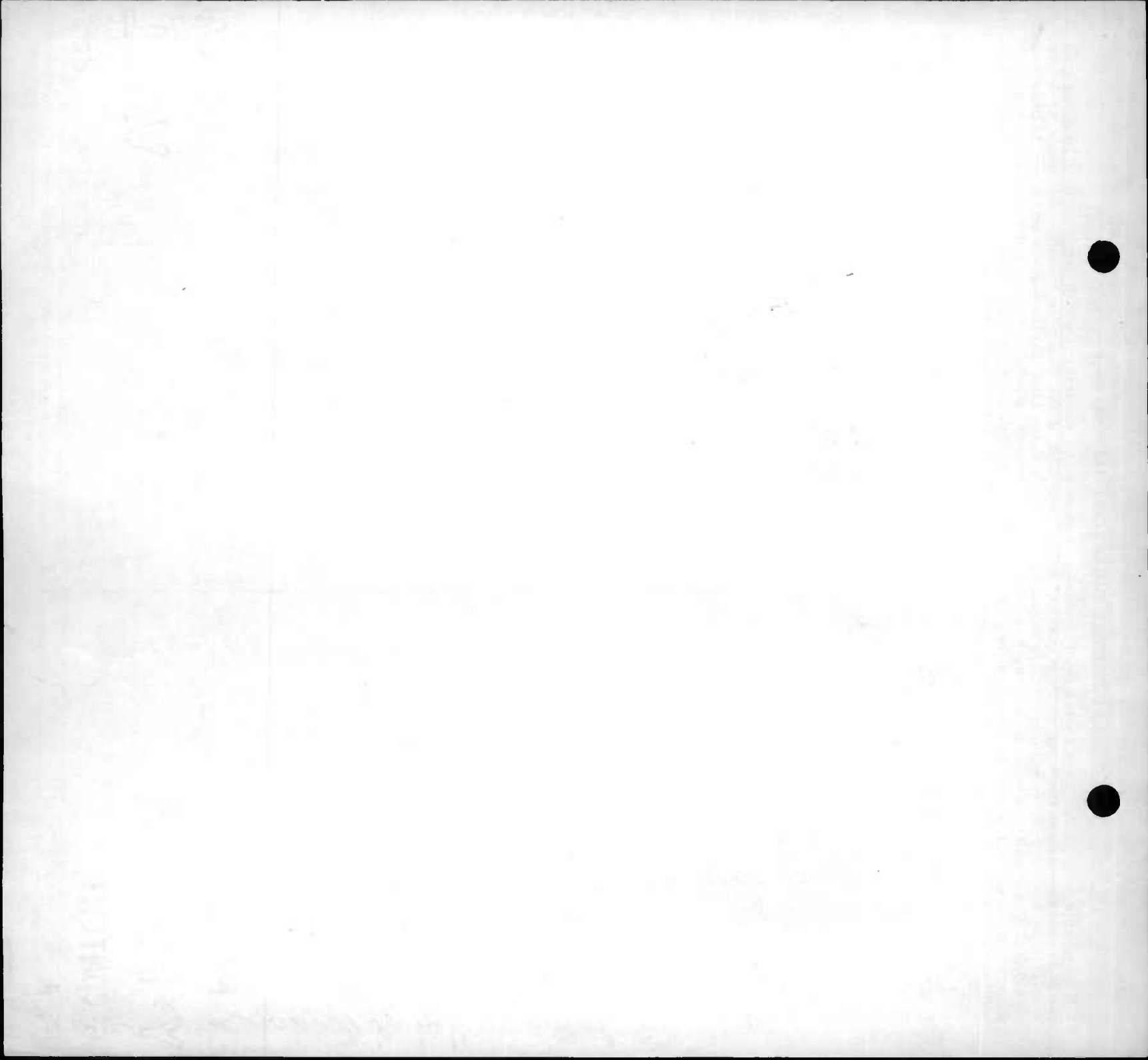
Several years |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from April 15 19 67 to April 26 19 67 , that (I) (we) last saw the deceased alive on April 25 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Loy M. Zimmerman | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
4/26/67 |
| 23C. PHYSICIAN'S NAME (Type)
Loy M. Zimmerman | | | 23D. ADDRESS
3202 Harford Rd Baltimore, Md. | | |
| 24A. BURIAL CREMATION REMOVAL (Specify)
Burial | | 24B. DATE
4/29/67 | | 24C. NAME OF CEMETERY or CREMATORY
Holy Redeemer Cemetery | |
| | | | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 27 1967 | | 25B. NAME OF REGISTRAR
Robert E. Jackson | | 25C. FUNERAL DIRECTOR
Leonard J. Ruck, Inc. Balto. Md. 21214 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 4138 | |
|--|---------------------|---|--|--|--|
| BIRTH NO. 67 4138 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) JOSEPH P. GUNNING | | 2. DATE AND HOUR OF DEATH
4-25-67 P. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
LITTLE SISTERS OF THE POOR
90 1200 VALLEY STREET
BALTIMORE, MARYLAND 21202 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE
D. STREET ADDRESS (If rural, give location)
1200 VALLEY STREET | | | |
| 5. SEX
M | 6. RACE
W | 7. MARRIED, NEVER MARRIED
<input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED (specify) | | 8. DATE OF BIRTH
3-14-1893 | 9. AGE (In years last birthday)
74 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
ELEVATOR OPERATOR | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | |
| 13. FATHER'S NAME
MICHAEL J. GUNNING | | 14. MOTHER'S MAIDEN NAME
KATHERINE ELLIS | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
213-10-0751A | | 17. INFORMANT
LITTLE SISTERS OF THE POOR
ADDRESS
1200 VALLEY ST, BALTIMORE, MD. | |
| 18. 422.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
C.V.A. | | CAUSE OF DEATH
(A) C.V.A.
(B) A.S.C.U.D.
(C) | | | |
| 18. II
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1966 to 4.25 19 67 , that (I) (we) last saw the deceased alive on 4.25 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Stanley Ankudas | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
4.27.67 | |
| 23C. PHYSICIAN'S NAME (Type)
STANLEY ANKUDAS | | 23D. ADDRESS
M.D. 1101 MAIDEN CHOICE LANE BALTIMORE, MD. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
4/28/67 | | 24C. NAME of CEMETERY or CREMATORY
Baltimore | |
| 24D. LOCATION (City, town, or county) (State)
Baltimore | | 25A. DATE REC'D BY HEALTH DEPT.
APR 27 1967 | | 25B. NAME OF REGISTRAR
Philip Herwig | |
| 25C. FUNERAL DIRECTOR
Philip Herwig | | ADDRESS 2024 Orleans St | | | |



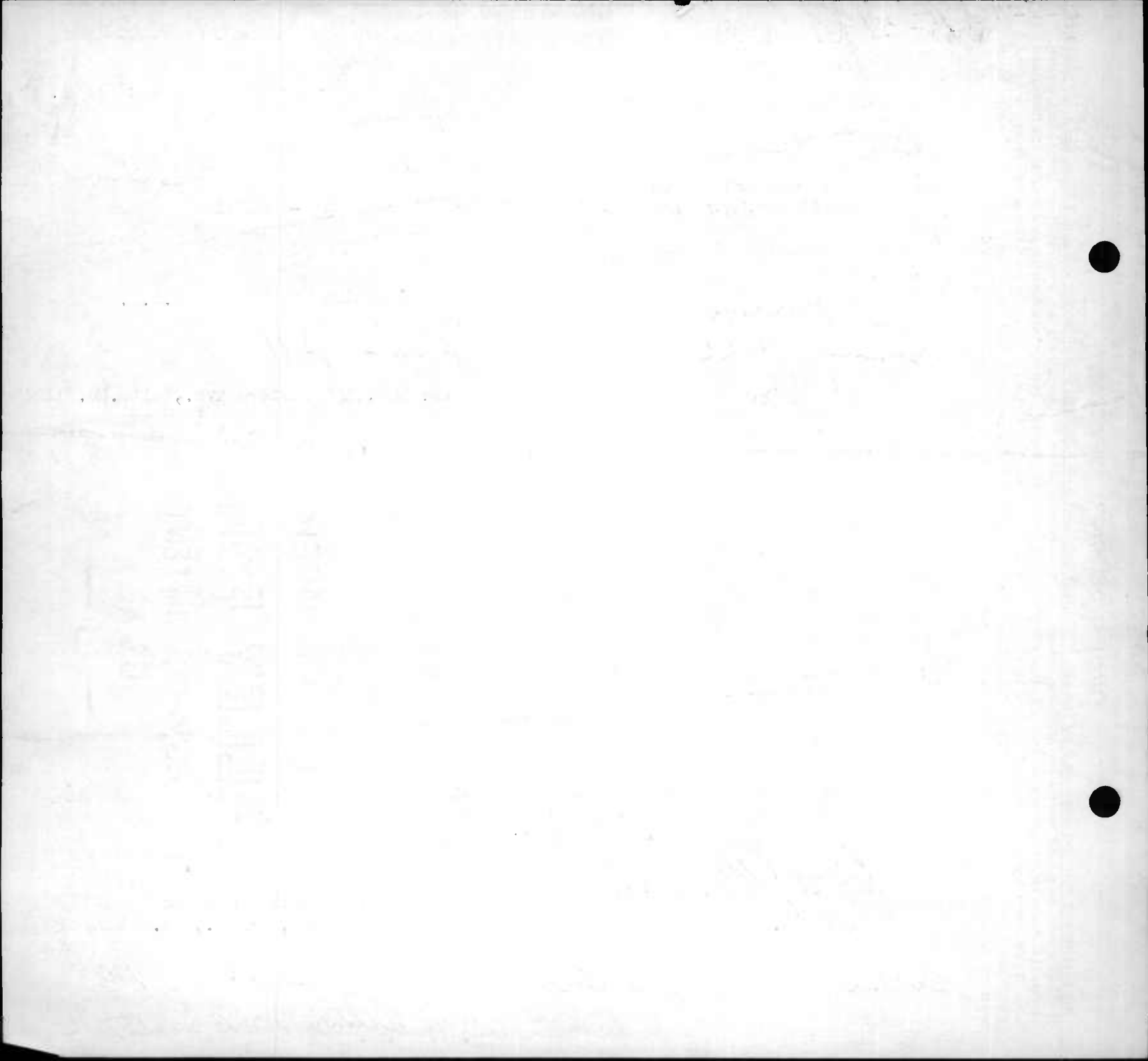
FUNERAL DIRECTOR: IMPORTANT

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| BALTIMORE CITY HEALTH DEPARTMENT | | | | Certificate of Death | | Registered No. 67 4139 | |
|---|-------------------------|---|--|---|--|--|--|
| BIRTH NO. 1-735 67 4139 | | M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) Alice LIGHTNER | | 2. DATE AND HOUR OF DEATH
4-26-67 10:00 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
31 BALTIMORE CITY HOSPITALS
4940 Eastern Avenue
Baltimore, Maryland 21224 | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY BALTO. Co
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE 53-00
D. STREET ADDRESS (If rural, give location)
846 NORRIS LANE - 21221 | | | |
| 5. SEX
FEMALE | 6. RACE
NEGRO | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
MARRIED | | 8. DATE OF BIRTH
1/05 | 9. AGE (In years last birthday)
61 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
SOUTH CAROLINA | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Sonny Hill | | | | 14. MOTHER'S MAIDEN NAME
Anna Hill | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
RECORDS: BCH, 4940 Eastern Ave., Balto. Md. 21224 | | | |
| 18. 443X14260X
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Multiple CVA's | | | | CAUSE OF DEATH
(A) DUE TO
HASCVD & Diabetes
(B) DUE TO
(C) | | INTERVAL BETWEEN ONSET AND DEATH
2 years

years | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (1) (this hospital) attended the deceased from 4-18 19 67 to 4-26 19 67 , that (1) (we) last saw the deceased alive on 4-26 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
David J. Mishelevich | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
4-26-67 | |
| 23C. PHYSICIAN'S NAME (Type)
DAVID J. MISHELEVICH | | | | 23D. ADDRESS BALTIMORE CITY HOSPITALS
4940 Eastern Avenue, Balto., Md. 21224 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
4-30-67 | | 24C. NAME OF CEMETERY OR CREMATORY
Mount Airy | | 24D. LOCATION (City, town, or county) (State)
Samuel Mel | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 27 1967 | | 25B. NAME OF REGISTRAR
Robert E. Johnson | | 25C. FUNERAL DIRECTOR
Shayla Wilson | | ADDRESS
1000 Brantley Ave | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 4140 | |
|--|---------------------|--|------------------------------------|---|---|
| BIRTH NO. 67 4140 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) DOLLIE (DOLLY) WASHINGTON (QUEEN) | | 2. DATE AND HOUR OF DEATH
4/26/67 7⁰⁰ A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE MD.
B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
SINAI HOSPITAL OF BALTIMORE | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE 28-02 | | D. STREET ADDRESS (If rural, give location)
4211 SPRINGDALE AVE | |
| 5. SEX
F | 6. RACE
N | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
WID | 8. DATE OF BIRTH
5/10/87 | 9. AGE (In years last birthday) 79 | If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
MD. | |
| 13. FATHER'S NAME
JOHN QUEEN | | 14. MOTHER'S MAIDEN NAME
MARY E. QUEEN | | 12. CITIZEN OF WHAT COUNTRY?
U.S. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
215-09-0089 | | 17. INFORMANT ADDRESS
CHART | |
| 18. 260X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Arteriosclerotic cardiovascular ulcer heart disease
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
DIABETES MELLITUS
PERIPHERAL VASCULAR DISEASE & GANGRENE | | CAUSE OF DEATH
(A) DUE TO
(B) DUE TO
(C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH
AT LEAST 3 M.O.
AT LEAST 3 DA. | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 4/24/67 19 to 4/26 19 67 , that (I) (we) last saw the deceased alive on 4/26 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Sheldon Frank | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
4/26/67 | |
| 23C. PHYSICIAN'S NAME (Type)
SHeldon FRANK | | 23D. ADDRESS
SINAI HOSPITAL OF BALTIMORE | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
5/1/67 | | 24C. NAME of CEMETERY or CREMATORY
BALTO NAT. CEM. | |
| 24D. LOCATION (City, town, or county) (State)
BALTO, MD | | 25A. DATE REC'D BY HEALTH DEPT.
APR 27 1967 | | 25B. NAME OF REGISTRAR
Robert E. Taylor | |
| 25C. FUNERAL DIRECTOR
WM. C. MARCH | | ADDRESS
928 E. NORTH AVE | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>67 4141</u> | |
|--|------------------|--|---|--|--|
| BIRTH NO. <u>67 4141</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) <u>Bacon, Pearl</u> | | 2. DATE AND HOUR OF DEATH
<u>4/24/67</u> <u>12:21 P.</u> M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <u>md</u> B. COUNTY <u>Balto</u> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>48 Maryland General Hospital</u> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>Balto</u> | | | |
| | | D. STREET ADDRESS (If rural, give location)
<u>2303 Entaw St. Place</u> | | | |
| 5. SEX <u>F</u> | 6. RACE <u>C</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
<u>Married (wid)</u> | 8. DATE OF BIRTH
<u>July 2, 1926</u> | 9. AGE (In years last birthday)
<u>40</u> | 10. If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>-</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Richmond Co., Va.</u> | |
| 13. FATHER'S NAME
<u>Taylor Laws</u> | | 14. MOTHER'S MAIDEN NAME
<u>Cora Jackson</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>229-23-1739</u> | | 17. INFORMANT
<u>Chart</u> | |
| 18. <u>330 X I</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) <u>Subarachnoid hemorrhage</u>
DUE TO
(B) <u>Hypertension, essential</u>
DUE TO
(C) _____ | | INTERVAL BETWEEN ONSET AND DEATH | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
<u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<u>NO</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>4/24</u> 19 <u>67</u> to <u>4/24</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4/29</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>Daniel C. Wilkerson</u> | | | | 23B. DATE SIGNED
<u>4/24/67</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>Daniel C. Wilkerson</u> | | | | 23D. ADDRESS
<u>421 Regester Ave (Bart 12)</u> | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>4/29/67</u> | | 24C. NAME of CEMETERY or CREMATORY
<u>Mt. Zion Baptist Church, Downing, Va.</u> | |
| 24D. LOCATION (City, town, or county) (State)
<u>Richmond Co., Va.</u> | | 25A. DATE REC'D BY HEALTH DEPT.
<u>APR 27 1967</u> | | | |
| 25B. NAME OF REGISTRAR
<u>Robert E. Jackson</u> | | 25C. FUNERAL DIRECTOR
<u>Williams Funeral Home 3197 Schroeder St.</u> | | | |

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(1)

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | Registered No. 67 4142 | | | |
|---|-----------------|---|---|---------------------------------------|----------------------------|---|-----------------------------|--|--|------------------------|--|----------------------------------|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | | | |
| BIRTH NO. 67 4142 | | | | | | | | | | | | | |
| M.E. CASE NO. | | | | | | | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) JAMES S. MARTIN | | | | | | 2. DATE AND HOUR OF DEATH
4-25-67 11:30 P.M. | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | | | | |
| FULL NAME OF INSTITUTE (If not in hospital or institution, give street address or location)
48 Md Gen Hosp
Balto., Md 21201 | | | | | | A. STATE B. COUNTY
Maryland | | | | | | | |
| | | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore 20-01 | | | | | | | |
| | | | | | | D. STREET ADDRESS (If rural, give location)
205 N. Monroe St. | | | | | | | |
| 5. SEX
M | 6. RACE
Neg. | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
MARRIED | 8. DATE OF BIRTH
11-11-16 | 9. AGE (In years last birthday)
50 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
construction | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | 11. BIRTHPLACE (State or foreign country)
North Carolina | | | 12. CITIZEN OF WHAT COUNTRY
USA | | | | |
| 13. FATHER'S NAME
JAMES M. MARTIN | | | | | | 14. MOTHER'S MAIDEN NAME
Ida Unknown | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | | 16. SOCIAL SECURITY NO.
241-01-9177 | | | 17. INFORMANT
Kenneth R Koskinen, MD | | | ADDRESS | | | | |
| 18. 592 X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | CAUSE OF DEATH
(A) Chronic Glomerular Tubular Nephritis
DUE TO
(B) Chronic -
DUE TO
(C) | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No)
YES | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 4/25/67 to 4/25 19 67, that (I) (we) last saw the deceased alive on 4/25 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 23A. SIGNATURE
Kenneth R Koskinen M.D. | | | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | 23B. DATE SIGNED
4/25/67 | | | | |
| 23C. PHYSICIAN'S NAME (Type)
KENNETH R. KOSKINEN M.D. | | | | | | 23D. ADDRESS
Md Gen Hosp Balto md | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | | 24B. DATE
4-30-67 | | | 24C. NAME of CEMETERY or CREMATORY
Roadside Cem. | | | 24D. LOCATION (City, town, or county) (State)
Hereford N.C. | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | | 25B. NAME OF REGISTRAR | | | 25C. FUNERAL DIRECTOR
Horton & Dyck F.H. | | | ADDRESS
1701 LAURELS | | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|----------------------|--|--------------------------------|--|--|
| BIRTH NO. 5-363 67 4143 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 4143 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) <i>Sadie Stewart</i> | | 2. DATE AND HOUR OF DEATH
<i>4/25/67</i> <i>1320</i> P. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<i>31 BALTIMORE CITY HOSPITALS
4940 EASTERN AVENUE
BALTIMORE 21224, MARYLAND</i> | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <i>BALTIMORE</i>
B. COUNTY <i>MARYLAND</i>
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>14-02</i>
D. STREET ADDRESS (If rural, give location) <i>1411 DIVISION ST. #21217</i> | | | |
| 5. SEX <i>Female</i> | 6. RACE <i>Negro</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>WIDOW</i> | 8. DATE OF BIRTH <i>3-8-96</i> | 9. AGE (In years last birthday) <i>71</i> | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>Home</i> | | 11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 13. FATHER'S NAME <i>DENNIS DORSEY</i> | | 14. MOTHER'S MAIDEN NAME <i>FRANCES DORSEY</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>219-16-3040A</i> | | 17. INFORMANT ADDRESS <i>RECORDS: BCH 4940 EASTERN AVENUE #21224</i> | |
| 18. <i>153.8 I</i>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
<i>Adenocarcinoma of Colon</i> | | CAUSE OF DEATH
(A) DUE TO
(B) DUE TO
(C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH
<i>6 mos</i> | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>NO</i> | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>4/22</i> 19 <i>67</i> to <i>4/25</i> 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>4/25</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>William A. Emerson</i> | | M.D. <input type="checkbox"/> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <i>4/25/67</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>DR. WILLIAM A. EMERSON</i> | | 23D. ADDRESS <i>BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE #21224</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i> | | 24B. DATE <i>4-29-67</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>Bush Park Cem.</i> | |
| 24D. LOCATION (City, town, or county) (State) <i>Cocksville, Md.</i> | | 25A. DATE REC'D BY HEALTH DEPT. <i>APR 27 1967</i> | | | |
| 25B. NAME OF REGISTRAR <i>Robert E. Taylor</i> | | 25C. FUNERAL DIRECTOR <i>Morgan + Pye T. F. H. 170 LAURENS</i> | | | |

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W-255

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 67 4144 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 4144

M.E. CASE NO.

| | | | |
|--|-------------------------|--|---------------------------------------|
| 1. NAME OF DECEASED
(Type or Print)
CHARLES H. WISSMAN | | 2. DATE AND HOUR PRONOUNCED DEAD
4-24-67 7:30 PM M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION
38 UNIVERSITY HOSPITAL | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Balt. Co.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore 53-00
D. STREET ADDRESS (If rural, give location)
6615 Richardson Road 21230 07 | |
| 5. SEX
Male | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
M. | 8. DATE OF BIRTH
12-16-1911 |
| 9. AGE (In years last birthday)
55 | | 10. BIRTHPLACE (State or foreign country)
MD | |
| 11. CITIZEN OF WHAT COUNTRY?
USA | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
HENRY H. WISSMAN | | 14. MOTHER'S MAIDEN NAME
ELLA M. MITCHEL | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)
— | | 16. SOCIAL SECURITY NO.
217.05.3929 | |
| 17. INFORMANT
THELMA WISSMAN SAME AS #4 | | ADDRESS | |
| 18. 416X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Rheumatic heart disease
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No)
No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Min.) | |
| 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>
CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ACTUAL SIGNATURE Werner U. Spitz M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
EXAMINER'S NAME (Type) WERNER U. SPITZ, M.D. ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>
DATE SIGNED 4-25-67 | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 23B. DATE
4/28/67 | |
| 23C. NAME OF CEMETERY OR CREMATORY
LORRAINE | | 23D. LOCATION (City, town, or county) (State)
WOODLAWN MD. | |
| 24A. DATE REC'D BY HEALTH DEPT.
APR 28 1967 | | 24B. NAME OF REGISTRAR
Robert E. Farkema | |
| 24C. FUNERAL DIRECTOR
J.T. STANSBURY | | 24D. ADDRESS
6411 WINDSOR MILL | |

Form 4/25/17
To the Secretary of the
Board of Directors

Director Thomas L. Johnson

Henry H. Johnson

Director of Western Union

12-14-17

1
5-432

67 4145

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 4145

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

CHARLES G. SCHULTHEIS

2. DATE AND HOUR PRONOUNCED DEAD

4-25-67

12:35 AM

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

ST. AGNES HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

B. COUNTY

a. a. Co.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

N. Linthicum

52-00

D. STREET ADDRESS (If rural, give location)

303 Regency Circle

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

12/29/32

9. AGE (In years
last birthday)

34

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Chauffeur

10B. KIND OF BUSINESS OR INDUSTRY

Truck

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Henry Schulteis

14. MOTHER'S MAIDEN NAME

Blanche Van Dyke

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

16. SOCIAL
SECURITY NO.

214-30-7460

17. INFORMANT

Bernardine Schulteis 303 Regency Circle

18.

E 976 X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

Gunshot wound of head

(A) _____
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) _____
DUE TO

(C) _____

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Partial

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, factory, street, office bldg.,
etc.)Front Yard of
Home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

303 Regency Circle - North
Linthicum, Maryland

52-00

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
4 24 '67 11:55

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Shot self in head with .22 cal revolver

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

WERNER U. SPITZ, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4-25-67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

4/27/67

23C. NAME OF CEMETERY or CREMATORY

Meadowridge Cemetery

23D. LOCATION

(City, town, or county)

Dorcy, Maryland

(State)

24A. DATE REC'D BY HEALTH DEPT.

APR 28 1967

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

Ambrise Inc 1328 S. Johns Rd

ADDRESS

WHITE PAPER

WHITE PAPER

WHITE PAPER

WHITE PAPER

WHITE PAPER

WHITE PAPER

WHITE PAPER

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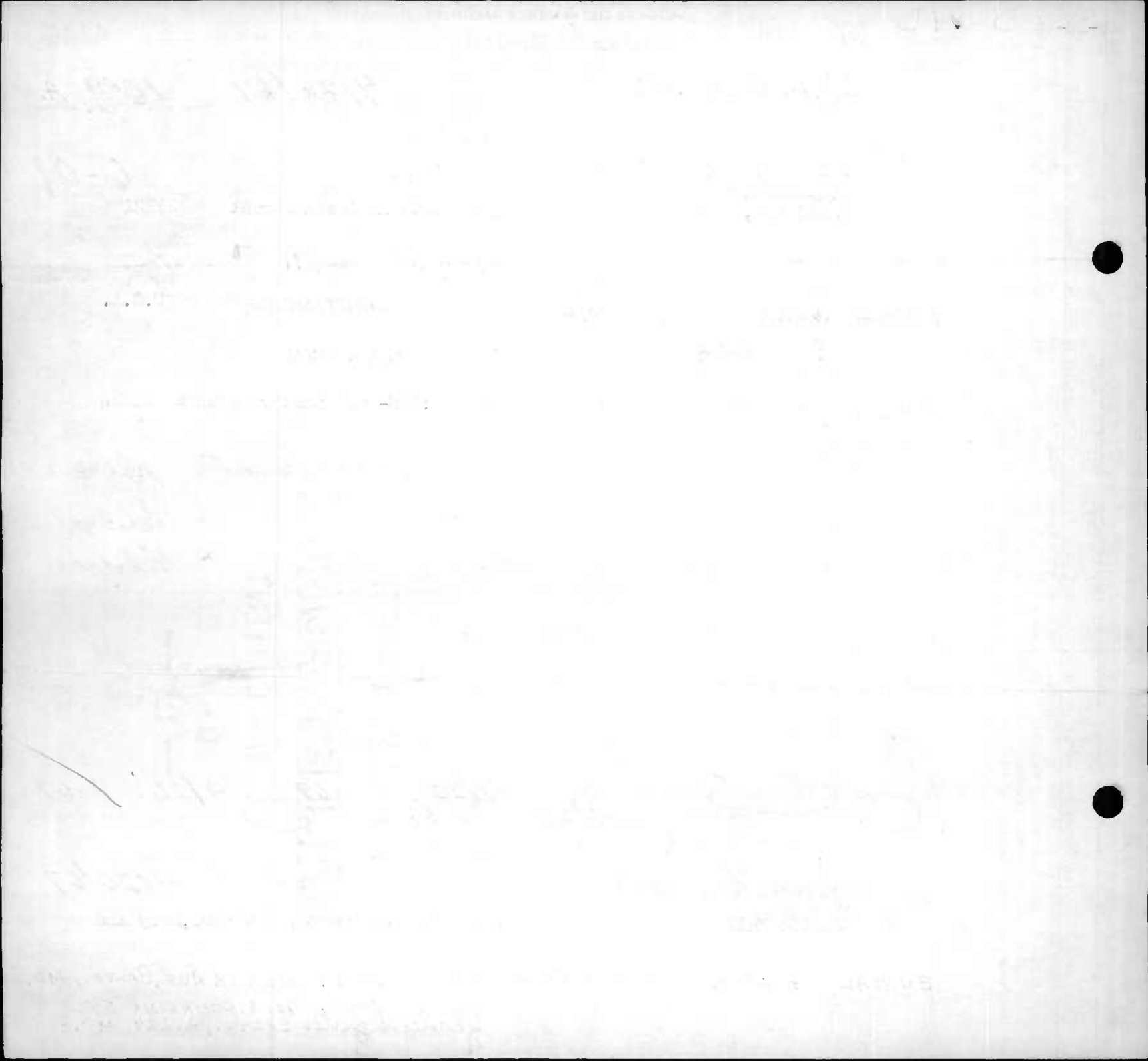
WHITE PAPER

49-13-26
FR

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 4146 | |
|---|-------------------------|---|------------------------------------|--|---|
| CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. 67 4146 | | M.E. CASE NO. | | | |
| 1. NAME OF DECEASED
(Type or Print) <i>Lillie C. Duvall</i> | | 2. DATE AND HOUR OF DEATH
<i>4/26/67 1000 A.M.</i> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<i>31 Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland 21224</i> | | A. STATE <i>Maryland</i>
B. COUNTY | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<i>Baltimore</i> | | | |
| | | D. STREET ADDRESS (If rural, give location)
<i>316 North Robinson Street 21224</i> | | | |
| 5. SEX
<i>Female</i> | 6. RACE
<i>White</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
<i>Widowed</i> | 8. DATE OF BIRTH
<i>5/29/95</i> | 9. AGE (In years lost birthday)
<i>71 78</i> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>HOUSE WORK</i> | | 10B. KIND OF BUSINESS OR INDUSTRY
<i>AT HOME</i> | | 11. BIRTHPLACE (State or foreign country)
<i>Maryland, BALTIMORE,</i> | |
| 12. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 13. FATHER'S NAME
<i>? Jordan</i> | | | |
| 14. MOTHER'S MAIDEN NAME
<i>UNKNOWN</i> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>NO</i> | | | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
<i>Records: BCM-4940 Eastern Avenue 21224</i> | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
<i>420.1 I</i> | | CAUSE OF DEATH | | | |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | (A) <i>Respiratory Arrest</i> | | | |
| ANTECEDENT CAUSES | | (B) <i>CVA</i> | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) <i>MI</i> | | | |
| II | | INTERVAL BETWEEN ONSET AND DEATH
<i>10min</i> | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
<i>ASCVD</i> | | | | | |
| 19A. DATE OF OPERATION
<i>2</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<i>YES</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from <i>4/22</i> 19 <i>67</i> to <i>4/26</i> 19 <i>67</i> , that (1) (we) last saw the deceased alive on <i>4/26</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<i>Judith Hall</i> M.D. | | | | 23B. DATE SIGNED
<i>4/26/67</i> | |
| 23C. PHYSICIAN'S NAME (Type)
<i>Judith Hall</i> | | | | 23D. ADDRESS
<i>4940 Eastern Avenue, Baltimore, Maryland</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>BURIAL</i> | | 24B. DATE
<i>4-29-67</i> | | 24C. NAME OF CEMETERY or CREMATORY
<i>LOUDON PARK CEM.</i> | |
| 24D. LOCATION (City, town, or county) (State)
<i>3801 FREDERICK AVE. BALTO., MD.</i> | | 25A. DATE REC'D BY HEALTH DEPT.
<i>APR 28 1967</i> | | 25B. NAME OF REGISTRAR
<i>Robert E. Finkema</i> | |
| 25C. FUNERAL DIRECTOR ADDRESS
<i>901 S. CONKLING ST. BALTO., 21224, MD.</i> | | | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 4147 | |
|--|--------------|--|--|---|---|
| BIRTH NO. 67 4147 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | WILHELMINA A. SNYDER | | April 25, 1967 2:00 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION

610 S. East Ave.
Baltimore, 21224, Md. | | | A. STATE
MD.
B. COUNTY | | |
| | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore 2611 | | |
| | | | D. STREET ADDRESS (If rural, give location)
610 S. East Ave. # 21224, | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years
last birthday) | 10. If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. |
| Female | White | Married | Aug. 24, 1908 | 58 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| House Work | | At Home | | Baltimore, Md. | |
| 13. FATHER'S NAME
John Poetzel | | | 14. MOTHER'S MAIDEN NAME
Anna Mullaney | | |
| 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| No | | 220-05-2317 | | John C. Snyder Same. | |
| 18. 174 X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH
(A) DUE TO Metastatic Carcinoma of the rectum and urinary bladder
(B) DUE TO Carcinoma of the uterus
(C) _____ | | |
| INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 0 | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (the hospital) attended the deceased from December 19 66 to April 25 1967 , that (I) (we) last saw the deceased alive on April 24 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Melito M. Torres M.D. | | | | 23B. DATE SIGNED
4-26-67 | |
| 23C. PHYSICIAN'S NAME (Type)
Melito M. Torres | | | | 23D. ADDRESS
441 S. Ellwood Ave. Balto., 21224, Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 4-28-67. | | Sacred Heart Cemetery | |
| | | | | 24D. LOCATION (City, town, or county) (State)
7401 German Hill Rd. Ba. Co., Md. | |
| 25A. DATE RECEIVED BY HEALTH DEPT.
APR 28 1967 | | 25B. NAME OF REGISTRAR
Robert E. Farley, MD | | 25C. FUNERAL DIRECTOR
Charles S. Jailer | |
| | | | | 901 S. Conkling St. Balto., 21224, Md. | |

2

• • •

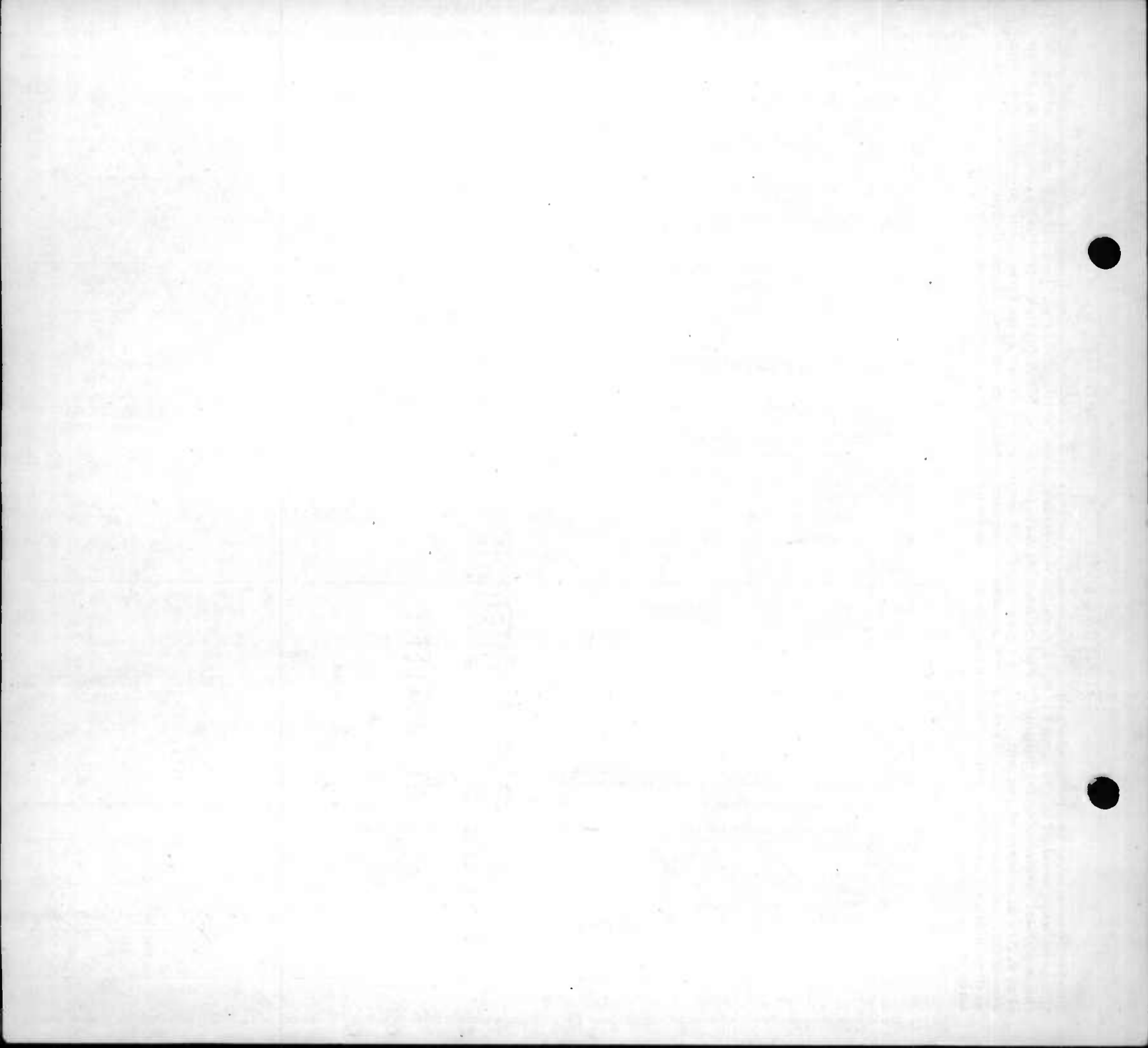
• *Chlorophyll a*

EXPERIMENTAL FIELD

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|--------------|--|-----------------------------|--|---|
| BIRTH NO.
67 4148 | | BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | Registered No. 67 4148 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
Rose Wdziecny | | 2. DATE AND HOUR OF DEATH
4-21-67 | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION
35 Church Home | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY Baltimore
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
3-02
D. STREET ADDRESS (If rural, give location)
838 S. Bond St | | | |
| 5. SEX
F | 6. RACE
W | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH
7-21-93 | 9. AGE (In years last birthday)
73 | If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 13. FATHER'S NAME
Edward Novak | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
213-09-8187 | | 17. INFORMANT
EUGENE Wdziecny | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)
260X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) ARTERIOSCLEROTIC HEART DISEASE
DUE TO
(B) DIABETIS MELLITIS
DUE TO
(C) | | INTERVAL BETWEEN ONSET AND DEATH
5 yrs
15 yrs. | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
D | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 7/15 1960 to 4/21 1967, that (I) (we) last saw the deceased alive on 4/3/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Dawn B Kaplan M.D. | | | | 23B. DATE SIGNED
4/24/67 | |
| 23C. PHYSICIAN'S NAME (Type)
Dawn B. Kaplan M.D. | | | | 23D. ADDRESS
129 S. Broadway Balto Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
4-25-67 | | 24C. NAME OF CEMETERY or CREMATORY
Holy ROSARY | |
| 24D. LOCATION
BALTO CT. Md. | | 25A. DATE REC'D BY HEALTH DEPT.
APR 28 1967 | | 25B. NAME OF REGISTRAR
RUBEN E. Salsbery | |
| 25C. FUNERAL DIRECTOR
RAYMOND L. KACZOROWSKI | | 25D. ADDRESS
4555 Forest St. #34 | | | |

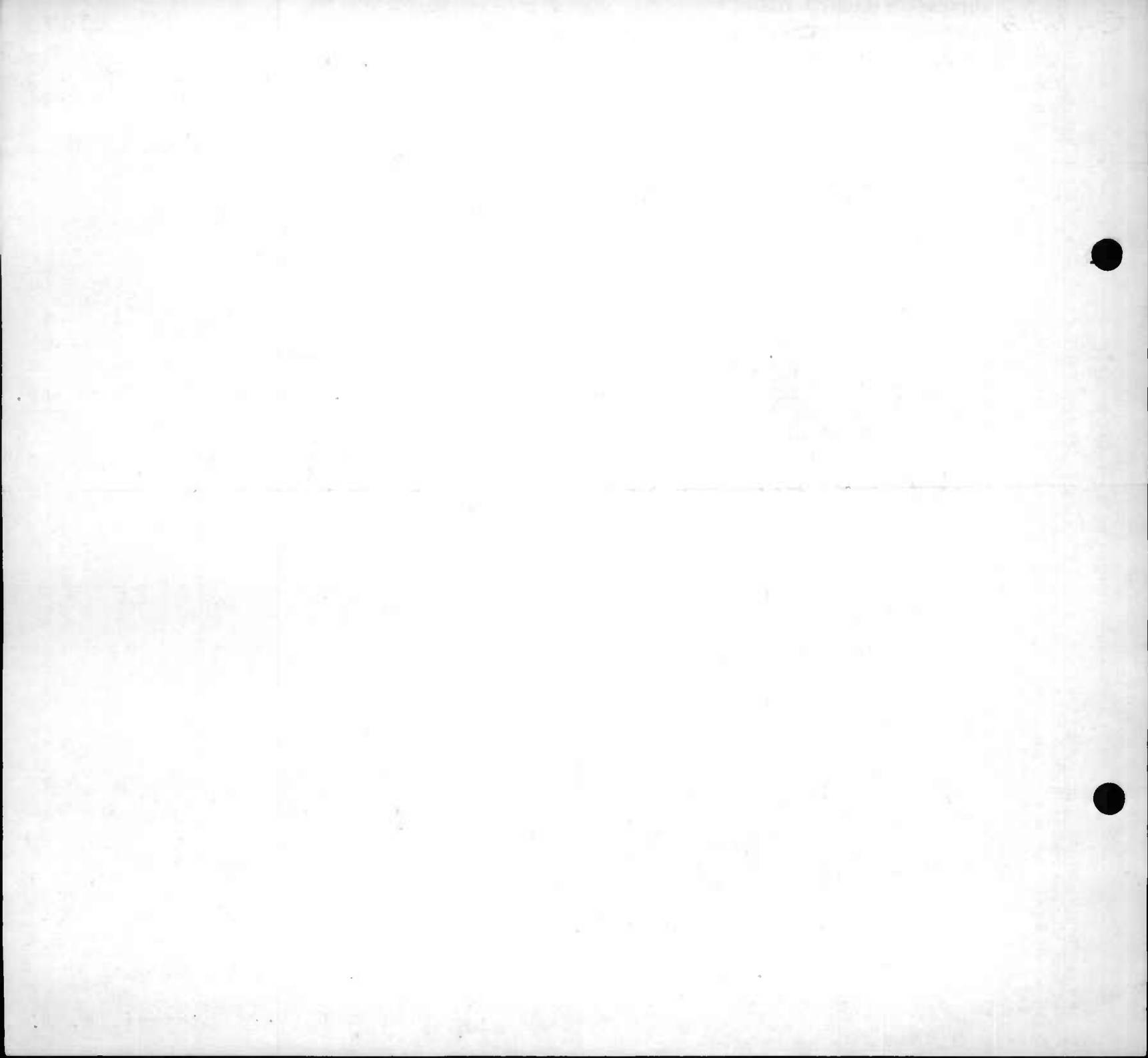


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | Registered No. | |
|--|---------------------|--|--|--|--|---|--|--|--|--|--|
| BIRTH NO. 67 4149 | | | | | | | | | | 67 4149 | |
| M.E. CASE NO. | | | | | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) LOUIS C CARPER | | | | | 2. DATE AND HOUR OF DEATH
4/26/67 5:45 A M. | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Bon Secours Hosp. | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND B. COUNTY BALTIMORE
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTO. City. #28 53-00
D. STREET ADDRESS (If rural, give location)
141 NEWBURG AVENUE | | | | | | |
| 5. SEX
M | 6. RACE
W | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
M | | 8. DATE OF BIRTH
10-11-02 | 9. AGE (If years lost birthday)
64 | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Hours: Min. | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
INVESTIGATOR | | | | 10B. KIND OF BUSINESS OR INDUSTRY
DUNN & BRADSTREET INC. | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
U.S. | | | |
| 13. FATHER'S NAME
ALBERT A. CARPER | | | | | 14. MOTHER'S MARDEN NAME
ANNIE SPINDLER | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
no 2 none | | | | 16. SOCIAL SECURITY NO.
212-01-8053 | | 17. INFORMANT ADDRESS
Mrs. Alice B. Carper 141 Newburg Ave. | | | | | |
| 18. 156.21
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)
Metastatic CA of liver
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Carcinomatosis etio (?) | | | | | | | | | | CAUSE OF DEATH
(A) Metastatic CA of liver
DUE TO
(B) Carcinomatosis etio (?)
DUE TO
(C) | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION
0 | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (N) (this hospital) attended the deceased from April 25 19 67 to April 26 19 67 , that (N) (we) last saw the deceased alive on April 26 19 67 and that in (N) (our) apinion death occurred on the date and hour and from the causes stated above. (N) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE
Milagros L. Guerrero M.D. | | | | | 23B. DATE SIGNED
April 26, 1967 | | | 23C. PHYSICIAN'S NAME (Type)
MILAGROS L. GUERRERO M.D. | | | |
| 23D. ADDRESS
Bon Secours Hospital | | | | | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
Apr. 29, 1967 | | 24C. NAME OF CEMETERY or CREMATORY
New Cathedral Cemt | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 28 1967 | | 25B. NAME OF REGISTRAR
CL. & E. F. ... | | 25C. FUNERAL DIRECTOR
STERLING FUNERAL ESTATE | | 25D. ADDRESS
736 Edmondson Av., Catonsville, Md. | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|-------------------------|---|---|--|--|
| BIRTH NO. 67 4150 | | BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | Registered No. 67 4150 | |
| 1. NAME OF DECEASED
(Type or Print) <u>MARIA GOSIN</u> | | | 2. DATE AND HOUR OF DEATH
<u>April 26, 1967</u> <u>5:45 A.M.</u> | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND
CERTIFICATE AMENDED
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>44 Union Memorial Hospital</u>
5-17-67 | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <u>MARYLAND</u>
B. COUNTY <u>BALTIMORE</u>
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>27-34</u>
D. STREET ADDRESS (If rural, give location) <u>3709 INA AVENUE</u> | | |
| 5. SEX
<u>FEMALE</u> | 6. RACE
<u>WHITE</u> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)
<u>MARRIED</u> | 8. DATE OF BIRTH
<u>07-07-1912</u> | 9. AGE (In years last birthday)
<u>55-54</u> | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>DOMESTIC LABOR</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>PRIV. HOME</u> | | 11. BIRTHPLACE (State or foreign country)
<u>POLAND</u> | |
| 13. FATHER'S NAME
<u>KRAMAR</u> | | | 14. MOTHER'S MAIDEN NAME
<u>UNKNOWN</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>NO</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
<u>JOHN M. GOSIN</u>
Son | |
| 18. <u>443X1</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
CAUSE OF DEATH
<u>Cerebral Hemorrhage</u>
(A) DUE TO <u>Hypertensive Arteriosclerosis</u>
INTERVAL BETWEEN ONSET AND DEATH
<u>12 mo.</u>
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.
<u>Hypertensive Arteriosclerosis</u>
<u>Cardiovascular disease</u>
(B) DUE TO
(C) | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
<u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<u>No</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>April 26</u> 19 <u>67</u> to <u>April 26</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>April 26</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>James W. Darty, Jr.</u>
M.D. | | | | 23B. DATE SIGNED
<u>4/26/67</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>JAMES W. DARTY, JR. M.D.</u> | | | | 23D. ADDRESS
<u>THE UNION MEMORIAL HOSPITAL</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | 24B. DATE
<u>4-29-67</u> | | 24C. NAME OF CEMETERY OR CREMATORY
<u>ST. MICHAEL'S CH.</u> | |
| 24D. LOCATION
<u>BALTO CT</u> | | 24E. (City, town, or county) | | 24F. (State) | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>APR 28 1967</u> | | 25B. NAME OF REGISTRAR
<u>R. E. Fickner</u> | | 25C. FUNERAL DIRECTOR
<u>Raymond L. Kaczorowski</u> | |
| 25D. ADDRESS
<u>3825 2nd St.</u> | | | | | |

V.S. 153

5-17-67

M.H.

WILLIAM J. COBLE, JR. . . . THE STATE OF TEXAS . . .

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

BERTHA POKORNA

2. DATE AND HOUR OF DEATH

4/23/67

2:55 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

BALTIMORE CITY HOSPITAL

4940 Eastern Avenue Baltimore, Md. #21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

MD.

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

BALTIMORE

D. STREET ADDRESS (If rural, give location)

524 S. BELNORD AVE #21224

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
married

8. DATE OF BIRTH

12-7-10

9. AGE (In years
last birthday)

56

If Under 1 Yr.
Months DaysIf Under 24 Hrs.
Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

ANTHONY OKONSKI

14. MOTHER'S MAIDEN NAME

LILLIAN KONALSKI

FRANCKOWIAK

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

17. INFORMANT

BCH 4940 Eastern Avenue
RECORDS: Baltimore, Md. #21224

ADDRESS

18. DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) DUE TO

(B) DUE TO

(C) DUE TO

INTERVAL BETWEEN
ONSET AND DEATH

54 years

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

4/21/67

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

RESPIRATORY INSUFFICIENCY

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4/11/67 to 4/23/67
that (I) (we) last saw the deceased alive on 4/23/67 and that in my (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

P. J. McLeod

M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

4/23/67

23C. PHYSICIAN'S
NAME (Type)

P. J. McLeod

M.D.

23D. ADDRESS

4940 Eastern Avenue

Baltimore, Md. #21224

24A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

24B. DATE

4-27-67

24C. NAME OF CEMETERY or CREMATORY

BALTO NAT'L

24D. LOCATION

(City, town, or county)

Baltimore

(State)

MD

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

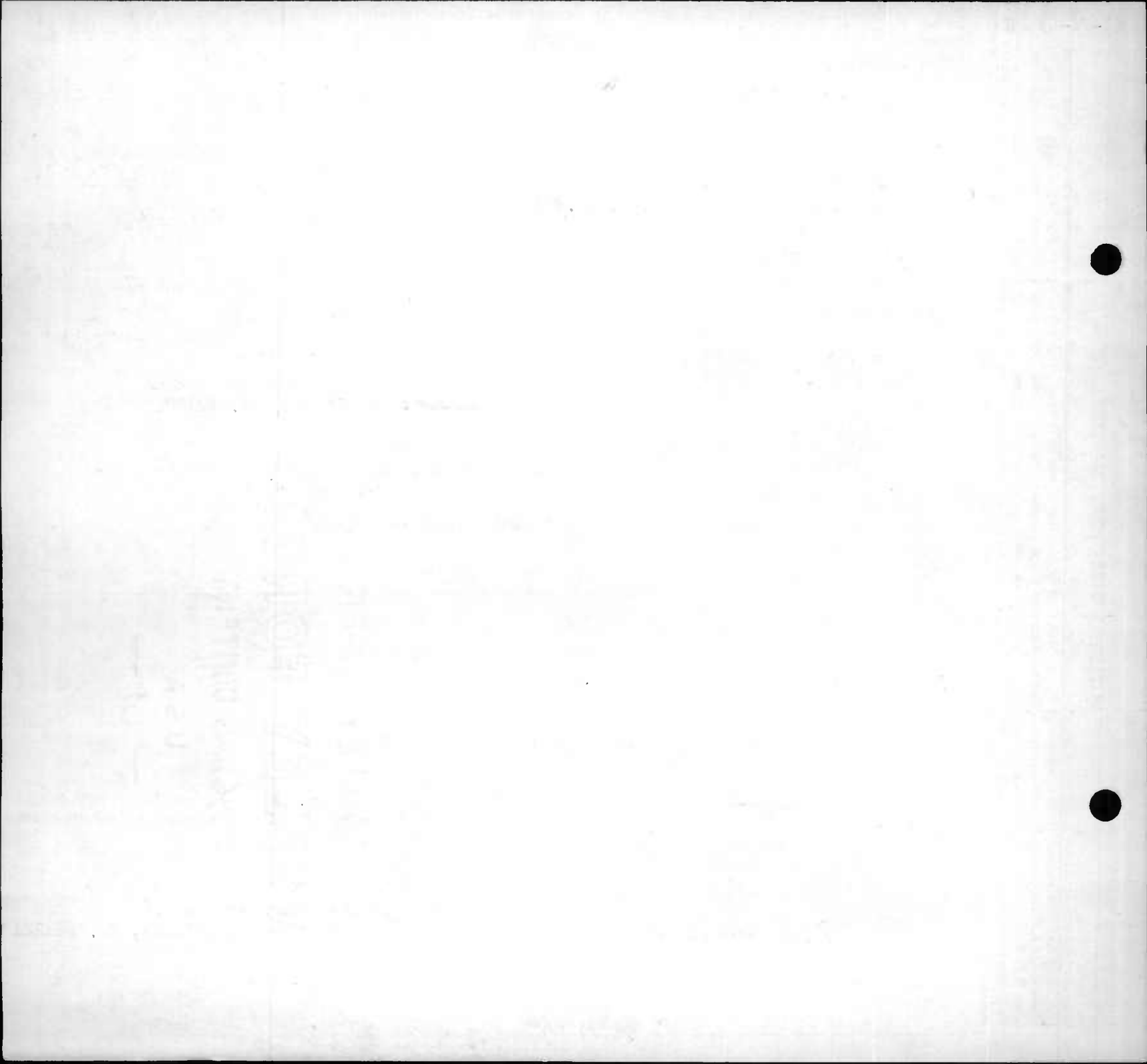
ADDRESS

APR 28 1967

RAYMOND L. KROZOWSKI

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | |
|--|-------------------------|--|---|---|--|--|--|--|--|--|
| BIRTH NO. 67 4152 | | | | | REGISTERED NO. 67 4152 | | | | | |
| M.E. CASE NO. | | | | | BALTIMORE CITY HEALTH DEPARTMENT | | | | | |
| 1. NAME OF DECEASED
(Type or Print) <u>Robert Arnold</u> | | | | | 2. DATE AND HOUR OF DEATH
<u>April 27, 1967 12:45 AM.</u> | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<u>90 Park Hill Nursing Home</u>
<u>1802 Eutaw Place</u> | | | | | A. STATE <u>MD</u>
B. COUNTY <u>Baltimore</u> | | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>Baltimore Md.</u> | | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location)
<u>1802 Eutaw Place</u> | | | | | |
| 5. SEX
<u>Male</u> | 6. RACE
<u>White</u> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<u>Widowed</u> | 8. DATE OF BIRTH
<u>4-20-1885</u> | 9. AGE (In years last birthday)
<u>72</u> | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>LABORER</u> | 11. BIRTHPLACE (State or foreign country)
<u>BALTO. MD</u> | 12. CITIZEN OF WHAT COUNTRY?
<u>U. S. A.</u> | 13. FATHER'S NAME
<u>Not Known - John Arnold</u> | 14. MOTHER'S MAIDEN NAME
<u>Not Known Laura</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>NO</u> | | | | | 16. SOCIAL SECURITY NO.
<u>214-01-1349</u> | | | | | 17. INFORMANT
<u>Mrs. Lillian Hutchens</u>
ADDRESS
<u>305 Vermont Ave #27</u> |
| 18. <u>433.1 I</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
<u>Inttractable Congestive Heart Failure</u>
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
<u>A.S.C.V.D.</u>
<u>Atrial Fibrillation due to (B)</u> | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | |
| 19A. DATE OF OPERATION
<u>0</u> | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No)
<u>No</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nately medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>5 - 17</u> 19 <u>66</u> to <u>April 27</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>April 26</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | |
| 23A. SIGNATURE
<u>Cesar Valle Cuervo</u> | | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | 23B. DATE SIGNED
<u>4-27-67</u> | | |
| 23C. PHYSICIAN'S NAME (Type)
<u>Dr. C. Cuervo</u> | | | | | 23D. ADDRESS
M.D. <u>Randallstown Md.</u> | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | 24B. DATE
<u>4/29/67</u> | | 24C. NAME OF CEMETERY or CREMATORY
<u>GLEN HAVEN CEM</u> | | | 24D. LOCATION (City, town, or county) (State)
<u>A.A. COUNTY MD</u> | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>APR 28 1967</u> | | | 25B. NAME OF REGISTRAR
<u>Dr. E. E. Johnson</u> | | | 25C. FUNERAL DIRECTOR
<u>KRAUSE FUNERAL HOME</u> | | | ADDRESS
<u>1216 S CHARLES ST</u> | |

Nursing home has 4-20-1888 - 79 yrs.

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|---|---------------|--|--|---|---|---|-------------------------------------|
| BIRTH NO. 67 4153 | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | Registered No. 67 4153 | |
| M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Paul Young | | | | 2. DATE AND HOUR OF DEATH 4/24/67 2:55p M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY Maryland | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 The Johns Hopkins Hospital | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | |
| | | | | D. STREET ADDRESS (If rural, give location) 3668 Dudley Avenue #13 | | | |
| 5. SEX male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 10/20/94 | 9. AGE (In years last birthday) 72 | If Under 1 Yr. Months: Days: Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sheet Metal Worker | | | 10B. KIND OF BUSINESS OR INDUSTRY Glen L. Martin Co. | | 11. BIRTHPLACE (State or foreign country) Hungary | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME John Young | | | | 14. MOTHER'S MAIDEN NAME Catherine Backas | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (yes, no or unknown) (If yes, give war or dates of service) no | | | | 16. SOCIAL SECURITY NO. 21-05-8133A | | 17. INFORMANT Elizabeth Young, wife, Above | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 19A. DATE OF OPERATION 1 4/24/67 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Ca of colon 20A. AUTOPSY? (Yes or No) NO 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | CAUSE OF DEATH (A) DUE TO Ventricular fibrillation (B) DUE TO Atherosclerosis + hypertensive cardiovascular disease (C) DUE TO During anaesthesia for colon surgery | | INTERVAL BETWEEN ONSET AND DEATH 40 minutes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? Death occurred during anesthesia induction | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 4/20 19 67 to 4/24 19 67, that (I) (we) last saw the deceased alive on 4/24 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Timothy J. Gardner | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 4/24/67 | |
| 23C. PHYSICIAN'S NAME (Type) Timothy J. Gardner | | | | 23D. ADDRESS M.D. The Johns Hopkins Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 4/27/67 | | 24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery | | 24D. LOCATION (City, town, or county) (State) Balto., Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. APR 28 1967 | | 25B. NAME OF REGISTRAR R. S. E. Johnson | | 25C. FUNERAL DIRECTOR Schimunek Funeral Home | | ADDRESS 3331 Brehms Lane #13 | |

Measurements of length and breadth in mm

4/24/03

Ca of color

no

from background

4/24

4/22/03

Counting stations

X

4/22/03

Black

of

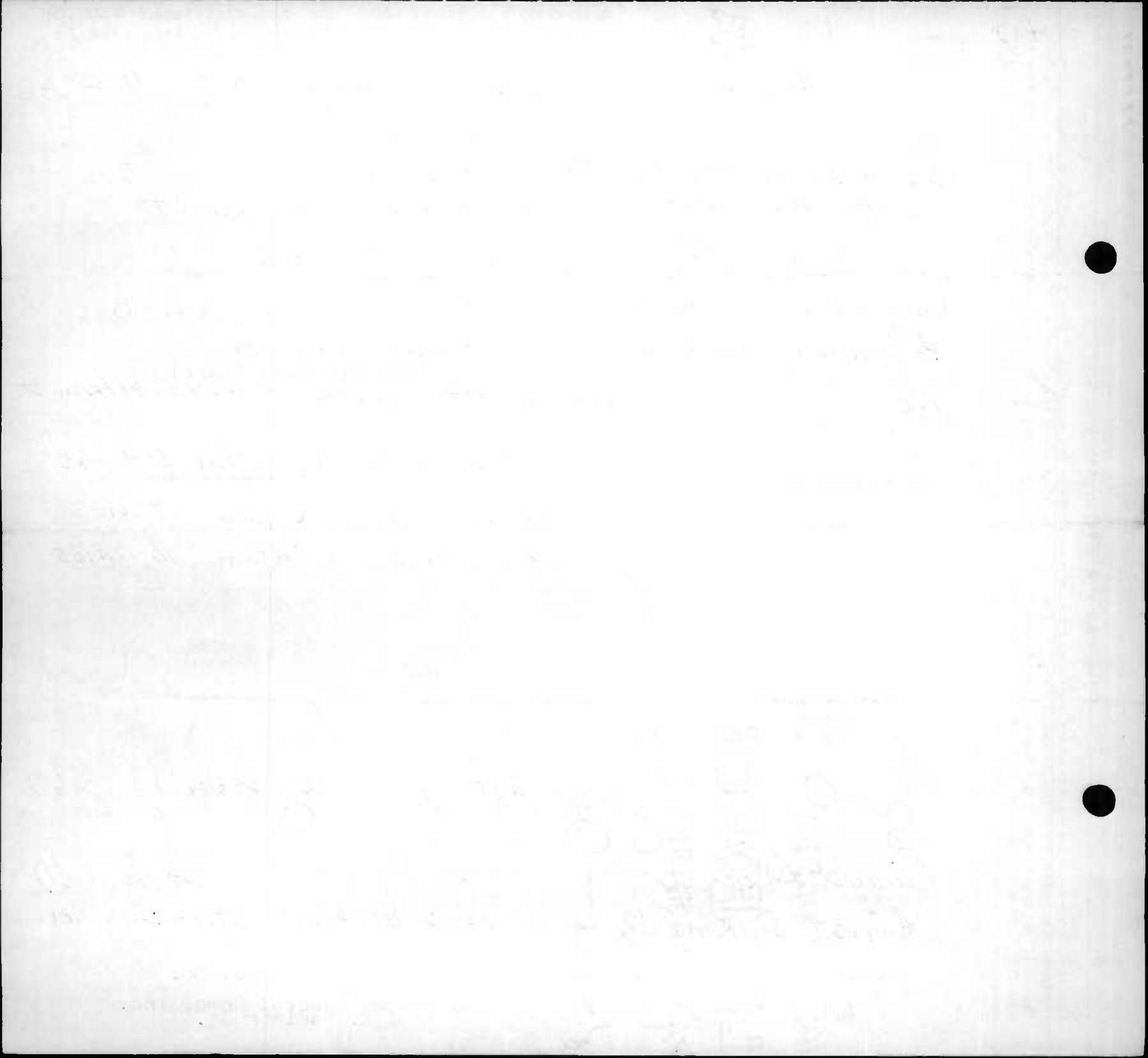
Butterfly

black and white

4/22/03

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

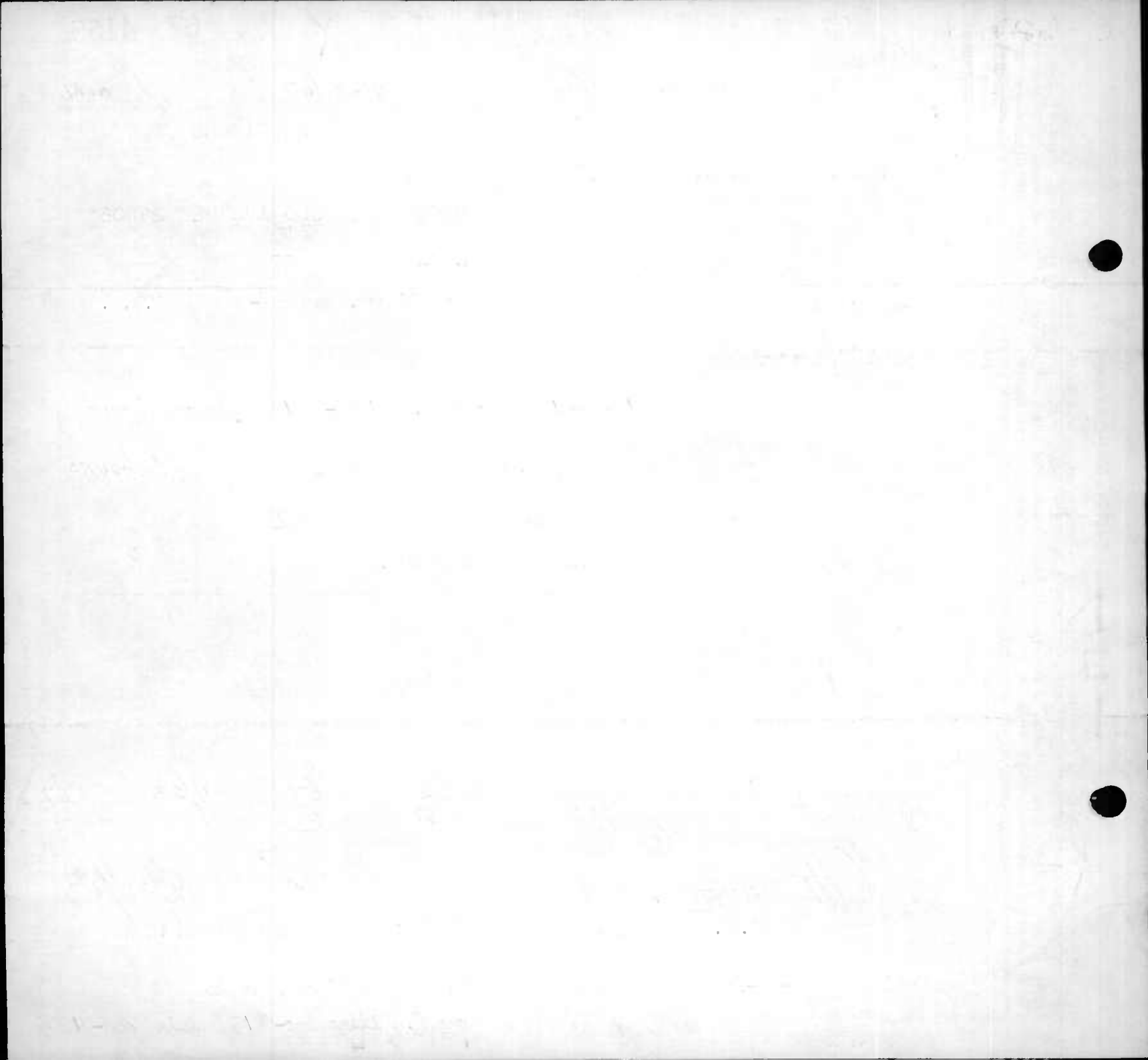
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|-----------------------|--|---|--|--|--|---|--|--|
| 67 4154 | | | | | Registered No. 67 4154 | | | | |
| BIRTH NO. | | | | | M.E. CASE NO. | | | | |
| 1. NAME OF DECEASED
(Type or Print) Melvin Leroy Sible | | | | | 2. DATE AND HOUR OF DEATH
24 April 1967 7 30 A.M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
2614 E. Jefferson St. Baltimore, Md. 21205 | | | | | A. STATE Maryland
B. COUNTY | | | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | | | | | D. STREET ADDRESS (If rural, give location)
2614 E. Jefferson St. | | | | |
| 5. SEX
Male | 6. RACE
Cau | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married | 8. DATE OF BIRTH
1 July 1908 | 9. AGE (In years last birthday)
58 | If Under 1 Yr. Months: Days | | If Under 24 Hrs. Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Carpenter | | | 10B. KIND OF BUSINESS OR INDUSTRY
self-employed | | 11. BIRTHPLACE (State or foreign country)
Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | |
| 13. FATHER'S NAME
William Franklin Sible | | | | | 14. MOTHER'S MAIDEN NAME
Annie Braum | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | 16. SOCIAL SECURITY NO.
218-14-7553 | | 17. INFORMANT Barbara (nee Sauer) Wife - 2614 E. Jefferson St. | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | | |
| | | | | | (A) Small Bowel Obstruction | | 3-4 wks | | |
| | | | | | (B) Metastatic Adenocarcinoma | | 4 mos. | | |
| | | | | | (C) Adenocarcinoma of Rectum | | 10-12 mos | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (1) (this hospital) attended the deceased from Sept 1966 to 24 April 1967 , that (2) (we) last saw the deceased alive on 23 April 1967 and that it is (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
August D. King Jr. | | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
24 April 67 | | |
| 23C. PHYSICIAN'S NAME (Type)
August D. King Jr. | | | | | 23D. ADDRESS
1202 St. Paul St. - Balto. Md. | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
4/27/67 | | 24C. NAME OF CEMETERY or CREMATORY
Holy Redeemer Cemetery | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 28 1967 | | 25B. NAME OF REGISTRAR
Robert E. Farber | | 25C. FUNERAL DIRECTOR ADDRESS
Schimunek Funeral Home, Inc. 2601 E. Madison St. | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|------------------|---|---|--|---|--|--|---------|--|
| 67 4155
CERTIFICATE OF DEATH | | | | | Registered No. 67 4155 | | | | |
| BIRTH NO. 67 4155 | | | | | 2. DATE AND HOUR OF DEATH 4/23/67 1 A.M. | | | | |
| M.E. CASE NO. | | | | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | |
| 1. NAME OF DECEASED (Type or Print) CRIST, Kathryn A. | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND B. COUNTY BALTIMORE C. | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
33 THE JOHNS HOPKINS HOSPITAL | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE 53-00 | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location)
5319 HAZELWOOD AVENUE 21206 | | | | |
| 5. SEX
FEMALE | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
MARRIED | 8. DATE OF BIRTH
2-22-10 | 9. AGE (In years last birthday)
57 | If Under 1 Yr. Months: Days: Hours: Min. | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Baltimore, Maryland- | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | |
| 13. FATHER'S NAME
ALBERT SYLVESTER | | | | | 14. MOTHER'S MAIDEN NAME
LOUISE BLAIR | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO.
212-07-0127 | | 17. INFORMANT
Frank W. Crist - 5219 Hazlewood Avenue | | | ADDRESS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
260X14-159X
DIABETIC KETOACIDOSIS
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
POSSIBLE OCCULT GI
Neoplasm | | | | | INTERVAL BETWEEN ONSET AND DEATH
9 hours. | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION
2 | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)
(APPROX.) | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 4/22 19 67 to 4/23 19 67, that (I) (we) last saw the deceased alive on 4/23 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
C.H. Brown, III, M.D. | | | | | 23B. DATE SIGNED
4/23/67 | | | | |
| 23C. PHYSICIAN'S NAME (Type)
C.H. BROWN 3RD M.D. | | | | | 23D. ADDRESS
THE JOHNS HOPKINS HOSPITAL | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
4-26-67 | | 24C. NAME of CEMETERY or CREMATORY
Holy Redeemer Cemetery | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 28 1967 | | | 25B. NAME OF REGISTRAR
Robert E. Taylor | | 25C. FUNERAL DIRECTOR
John C. Miller Inc-415 Belair Road-21206 | | | ADDRESS | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Certificate of Death | | Registered No. 67 4156 | |
|---|---------------------|---|------------------------------------|--|--|--|-----------------------|
| BIRTH NO. 67 4156 | | | | | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) DIX MRS MICHAELNA | | | | 2. DATE AND HOUR OF DEATH
4/27/67 4-15p.m. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
35 Church home & hospital. | | (If not in hospital or institution, give street address or location) | | A. STATE Md. B. COUNTY Baltimore | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give town) | | | |
| | | | | D. STREET ADDRESS (If rural, give location) | | | |
| | | | | 2220 FLEET ST | | | |
| 5. SEX
F. | 6. RACE
W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
Married | 8. DATE OF BIRTH
8-26-05 | 9. AGE (In years last birthday)
61 yrs | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife. | | 10B. KIND OF BUSINESS OR INDUSTRY
- | | 11. BIRTHPLACE (State or foreign country)
Md. | | 12. CITIZEN OF WHAT COUNTRY?
America. | |
| 13. FATHER'S NAME
Theodore Maleszski. | | | | 14. MOTHER'S MAIDEN NAME
Lottie Cwalina | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
unknown. | | 16. SOCIAL SECURITY NO.
212-22-4300 | | 17. INFORMANT
FRANK DIX | | ADDRESS
2220 FLEET ST. | |
| 18. 434.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, assthenia, etc. It means the disease, injury or complication which caused death.)
Congestive Heart Failure
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
uremia | | | | (A) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH
Several years | |
| | | | | (B) DUE TO | | | |
| | | | | (C) DUE TO | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 4/15 19 67 to 4/27 19 67 , that (I) (we) last saw the deceased alive on 4/27 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
K.M. Anandain | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
4/27/67. | |
| 23C. PHYSICIAN'S NAME (Type)
K.M. ANANDAIN | | | | 23D. ADDRESS
Church home & hospital. Balti | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
5-1-67 | | 24C. NAME of CEMETERY or CREMATORY
HOLY ROSARY CEMETERY | | 24D. LOCATION (City, town, or county) (State)
BALTO MD. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR
John M. Weber & Sons Inc | | 25C. FUNERAL DIRECTOR ADDRESS
401 S. CHESTER ST | | | |

4-187

10/1/02

10/1/02

10/1/02

10/1/02

2220 FEET

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1
A-352

67 4157

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 4157

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

FRANCES ADAMS

2. DATE AND HOUR PRONOUNCED DEAD

4-25-67 10:15 AM M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

UNION MEMORIAL HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2238 Barclay Street

5. SEX

Female

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
SEPARATED

8. DATE OF BIRTH

5-17-1909

9. AGE (In years
last birthday)

58

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Domestic

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

unknown

14. MOTHER'S MAIDEN NAME

Mary Hunter

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

218-16-7312

17. INFORMANT

ADDRESS

ELVA Smith - 1542 Abbottsden St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Asphyxia
DUE TO

Edema of laryngeal inlet

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)
DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Acute laryngotracheobronchitis

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)

21D. TIME OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)

WERNER U. SPITZ, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

4-25-67

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

4/29/67

23C. NAME OF CEMETERY OR CREMATORY

Mt. Calvary

23D. LOCATION

(City, town, or county)

(State)

A.A. Co. Md

24A. DATE REC'D BY HEALTH DEPT.

APR 28 1967

24B. NAME OF REGISTRAR

W. E. E. E. E.

24C. FUNERAL DIRECTOR

MARSHALL W. JONES, JR.

1735 ADDRESS

HARFORD AVE

WILLIAM H. HARRIS

WILLIAM H. HARRIS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 4158 | |
|--|-------------------------|---|---|--|---|
| CERTIFICATE OF DEATH | | | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) Annie Williams | | 2. DATE AND HOUR OF DEATH
4/27/67 11:30 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
00 | | | A. STATE Maryland
B. COUNTY Baltimore
C. CITY OR TOWN (If outside city limits, write RURAL and give township) S-05
D. STREET ADDRESS (If rural, give location) 1820 N. Wolfe St. | | |
| 5. SEX
Female | 6. RACE
Negro | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
SEPARATED | 8. DATE OF BIRTH
6-30-1898 | 9. AGE (In years last birthday)
69 | If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
NONE | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
South Carolina | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 13. FATHER'S NAME
HECTOR MORRIS | | |
| 14. MOTHER'S MAIDEN NAME
ELLA McCALL | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | |
| 16. SOCIAL SECURITY NO.
26 09 0381 | | | 17. INFORMANT
Relatives
ADDRESS
1820 N. Wolfe St. | | |
| 18. 260X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last,
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Pneumonia | | | CAUSE OF DEATH
(A) Cerebral Thrombosis
DUE TO
(B) Arteriosclerosis
DUE TO
(C) Diabetes Mellitus | | |
| 19A. DATE OF OPERATION
0 | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | |
| 20A. AUTOPSY? (Yes or No)
No | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 9/12 1966 to 4/27 1967 , that (I) (we) last saw the deceased alive on 4/20 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Alvin Thompson | | | | 23B. DATE SIGNED
4/27/67 | |
| 23C. PHYSICIAN'S NAME (Type)
Alvin Thompson | | | | 23D. ADDRESS
1856 N. Wolfe St. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
5-1-67 | | 24C. NAME OF CEMETERY or CREMATORY
MT. AUBURN | |
| 24D. LOCATION (City, town, or county) (State)
BALTIMORE MD | | 25A. DATE REC'D BY HEALTH DEPT.
APR 28 1967 | | | |
| 25B. NAME OF REGISTRAR
Robert E. Jackson | | 25C. FUNERAL DIRECTOR
JOSEPH KNIGHT | | | |
| ADDRESS
1639 N. Broadway | | | | | |

UNITED STATES

DEPARTMENT OF JUSTICE

WASHINGTON, D. C.

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67 4159

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

67 4159

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

CATHERINE W. GOETZE

BROWNE
BROWNE

2. DATE AND HOUR PRONOUNCED DEAD

April 26, 1967 2:10 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF DECEASED IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION

1620 Lockwood Road

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1114 Broadview Apartments & 39th Street

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED

WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

1/31/1897

9. AGE (In years

last birthday)

70

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

Own Home

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

William August Goetze

14. MOTHER'S MAIDEN NAME

Sarah A. Weaver

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

213-42-4687

17. INFORMANT

ADDRESS

Mr. J. Prentiss Browne, 1620 Lochwood Rd.

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) Barbiturate Intoxication.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

House

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

1620 Lockwood Road

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

4

26

'67

P

21E. INJURY OCCURRED

WHILE AT WORK

NOT WHILE AT WORK

21F. HOW DID INJURY OCCUR?

Ingestion of overdose of barbiturate.

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type)

Charles S. Petty

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4/27/67

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

4/28/1967

23C. NAME of CEMETERY or CREMATORY

Greenmount

23D. LOCATION (City, town, or county)

Baltimore,

(State)

Md.

24A. DATE RECD BY HEALTH DEPT.

APR 28 1967

24B. NAME OF REGISTRAR

Philip E. Jenkins

24C. FUNERAL DIRECTOR

H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.

ADDRESS

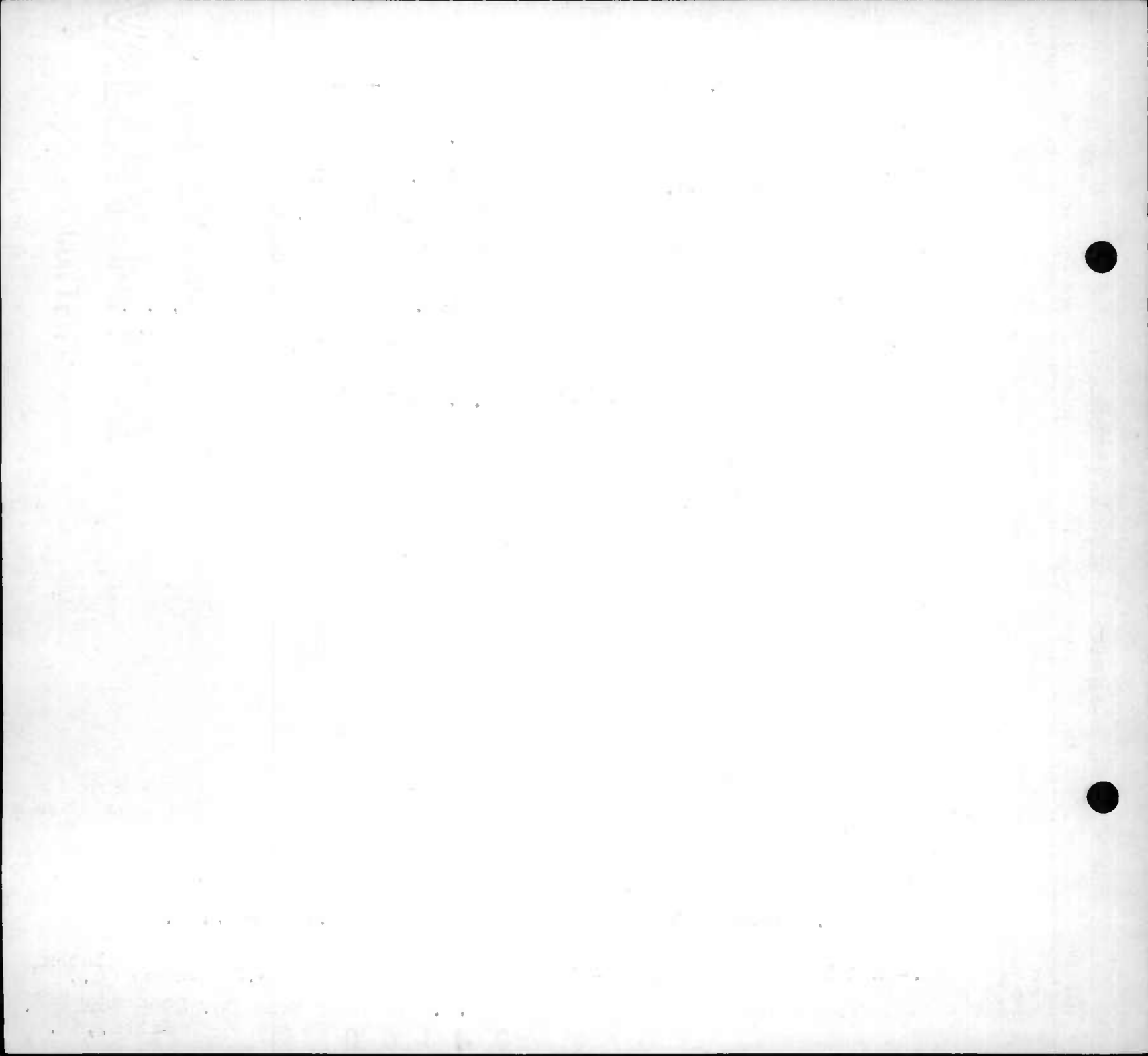
V.S. 153

5-2-67

M.H.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|---------------------|--|---|--|---|--|----------------------------------|--|--|
| BIRTH NO. 67 4160 | | | | | REGISTERED NO. 67 4160 | | BALTIMORE CITY HEALTH DEPARTMENT | | |
| M.E. CASE NO. | | | | | BALTIMORE CITY HEALTH DEPARTMENT | | | | |
| 1. NAME OF DECEASED
(Type or Print) Hattie R. Rich | | | | | 2. DATE AND HOUR OF DEATH
4-25-67 4 A M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY Balto. | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
00 14 Edgevale Rd. | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Balto. 21210 | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location)
14 Edgevale Rd. | | | | |
| 5. SEX
F | 6. RACE
W | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widowed | 8. DATE OF BIRTH
11/28/1870 | 9. AGE (In years last birthday)
96 | If Under 1 Yr. Months: Days | | If Under 24 Hrs. Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | | 10B. KIND OF BUSINESS OR INDUSTRY
Own Home | | 11. BIRTHPLACE (State or foreign country)
Miss. | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
David Rice | | | | | 14. MOTHER'S MAIDEN NAME
Pauline Cromlein | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | 16. SOCIAL SECURITY NO.
423-60-3252 | | 17. INFORMANT
A.R. Rich | | | ADDRESS
Above | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
332X1
Cerebral Thrombosis | | | | | INTERVAL BETWEEN ONSET AND DEATH
1 week | | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Arteriosclerosis | | | | | DUE TO
10 years | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Pneumonia | | | | | | | | | |
| 19A. DATE OF OPERATION
0 | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from April 18 1967 to April 25 1967 , that (I) (we) last saw the deceased alive on April 24 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
L. Morton Gaines Jr. M.D. | | | | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | 23B. DATE SIGNED
April 25, 1967 | |
| 23C. PHYSICIAN'S NAME (Type)
L. Morton Gaines Jr. M.D. | | | | | 23D. ADDRESS
7800 York Rd., Balto., Md. | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Rem.-Burial | | | 24B. DATE
4/26/67 | | 24C. NAME OF CEMETERY or CREMATORY
Emanu-el | | | 24D. LOCATION (City, town, or county) (State)
Birmingham, Jefferson Co., Alabama | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 28 1967 | | | 25B. NAME OF REGISTRAR
9670004160 | | 25C. FUNERAL DIRECTOR ADDRESS
H.W. Jenkins & Sons Co. 4905 York Rd. Balto., Md. | | | | |



w-425

67 4161

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 4161

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

SARAH IRWIN WILSON

2. DATE AND HOUR PRONOUNCED DEAD

4-25-67

5:45 PM.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

SINAI HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4408 Newport Avenue 21211

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Never Married

8. DATE OF BIRTH

8/3/1885

9. AGE (In years
last birthday)

81

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired-Assistant

10B. KIND OF BUSINESS OR INDUSTRY

Dentistry

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

William Vance Wilson

14. MOTHER'S MAIDEN NAME

Susan Irwin

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown; If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

213-09-7288

17. INFORMANT

Chevy Chase, Md.
Mrs. John Schubert, 5317 Baltimore Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B)
DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☒

DATE SIGNED

ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

RUSSELL S. FISHER, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

4-26-67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

4/27/1967

23C. NAME OF CEMETERY or CREMATORY

Woodlawn

23D. LOCATION

(City, town, or county)

(State)

Woodlawn, Balto. Co., Md.

24A. DATE REC'D BY HEALTH DEPT.

APR 28 1967

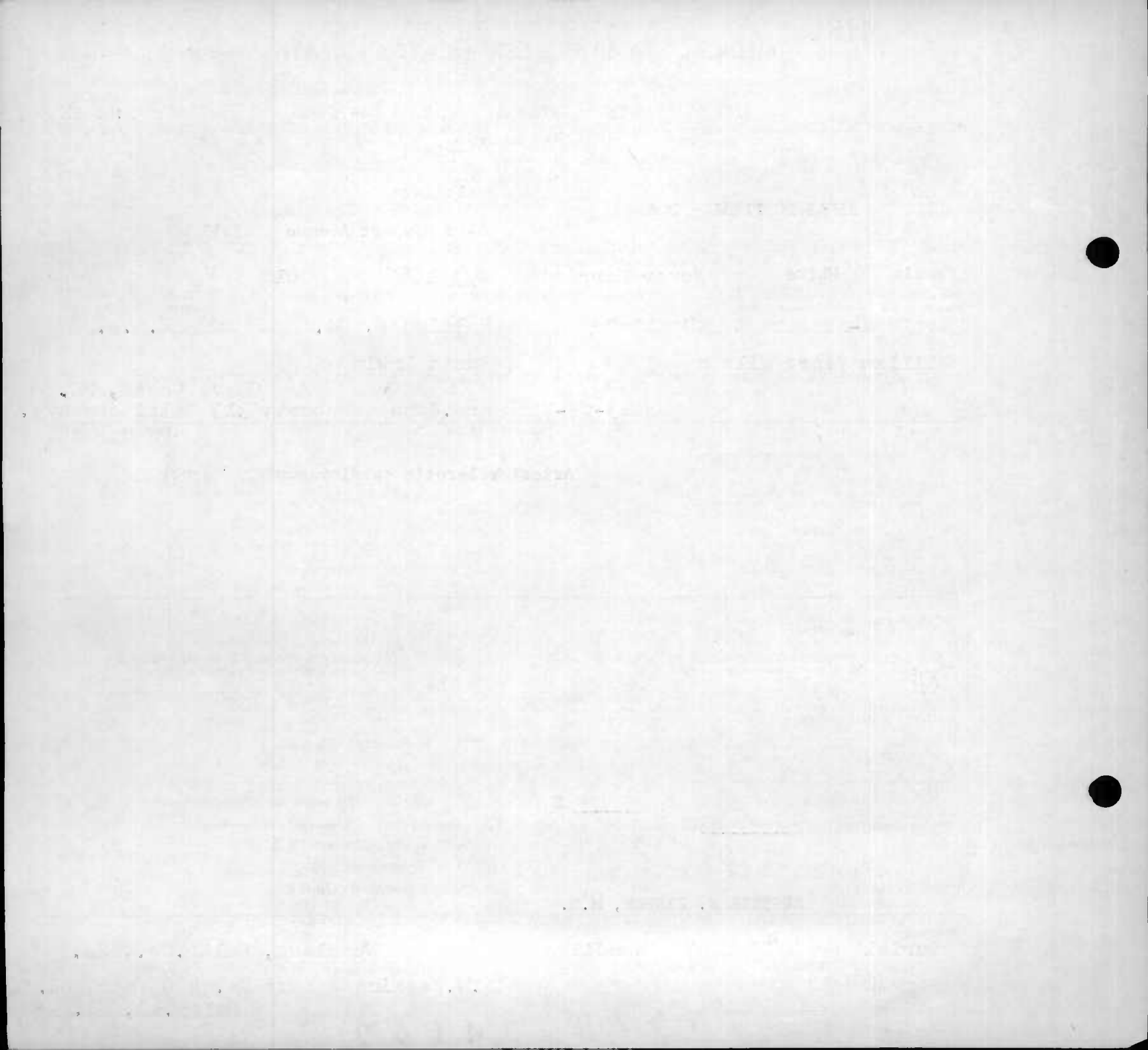
24B. NAME OF REGISTRAR

R. E. Fisher, M.D.

24C. FUNERAL DIRECTOR

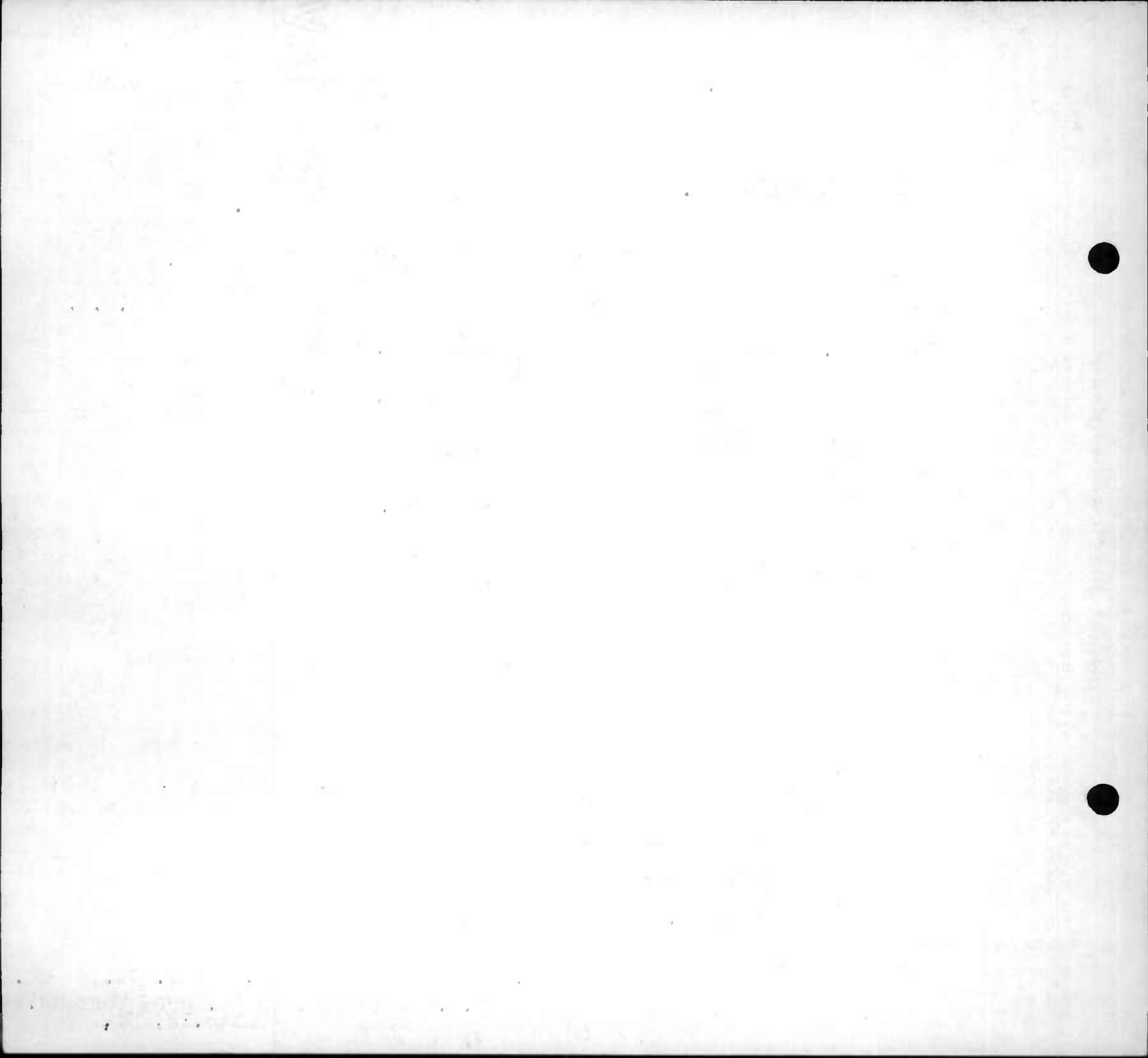
H.W. Jenkins & Sons Co. 4905 York Rd.
Balto. 12, Md.

ADDRESS



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|-----------|--|---|--|--|
| BIRTH NO. 67 4162 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 4162 | |
| M.E. CASE NO. | | | 2. DATE AND HOUR OF DEATH | | |
| 1. NAME OF DECEASED
(Type or Print) Laura I. Owens | | | 4/27/1967 9:30 A.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
3110 Ellerslie Ave. | | | A. STATE Maryland
B. COUNTY Baltimore 21218
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location)
3110 Ellerslie Ave. | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Never Married | 8. DATE OF BIRTH 7/26/1908 | 9. AGE (In years last birthday) 58 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Secretary | | 10B. KIND OF BUSINESS OR INDUSTRY
Food Fair | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 13. FATHER'S NAME
Richard E. Owens | | |
| 14. MOTHER'S MAIDEN NAME
Bertha E. Cook | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, na or unknown) (If yes, give war or dates of service)
No | | |
| 16. SOCIAL SECURITY NO. | | | 17. INFORMANT ADDRESS
Robert F. Owens (Same) | | |
| 18. I 170 X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | CAUSE OF DEATH
(A) BROUCCHO PNEUMONIA
DUE TO
(B) GENERAL DEBILITY & INANITION
DUE TO
(C) GENERALIZED CARCINOMATOSIS
PRIMARY RT BREAST CANCER | | |
| INTERVAL BETWEEN ONSET AND DEATH
48 HRS
2 MO.
3 1/2 mo. | | | | | |
| MEDICAL CERTIFICATION | | | | | |
| 19A. DATE OF OPERATION
11/22/67 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
CA OF RT AXILLA & BREAST | | 20A. AUTOPSY? (Yes or No)
No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
<input type="checkbox"/> | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
<input type="checkbox"/> | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
<input type="checkbox"/> | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR?
<input type="checkbox"/> | |
| 22. I certify that (I) (this hospital) attended the deceased from 11-1-1966 to 4/26-1967, that (I) (we) last saw the deceased alive on 4/26/1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Anthony J. Thomas | | | | 23B. DATE SIGNED
4/27/67 | |
| 23C. PHYSICIAN'S NAME (Type)
Anthony J. Thomas | | | | 23D. ADDRESS
4600 York Road | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
4/29/1967 | | 24C. NAME OF CEMETERY or CREMATORY
Moreland Mem Park | |
| 24D. LOCATION
Parkville, Balto. Co., Md. | | 24E. LOCATION (City, town, or county) (State)
Balto. Co., Md. | | | |
| 25A. DATE RECEIVED BY HEALTH DEPT.
APR 28 1967 | | 25B. NAME OF REGISTRAR
R. E. Jenkins | | 25C. FUNERAL DIRECTOR ADDRESS
H.W. Jenkins & Sons Co. 1905 York Rd. Balto. 12, Md. | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 4163 | |
|---|----------------------|--|----------------------------|--|---|
| CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. 67 4163 | | | | | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED
(Type or Print)
Howard Leroy Sellman | | 2. DATE AND HOUR OF DEATH
April 22, 1967 11:55 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE B. COUNTY
Md. Baltimore Co. | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
Union Memorial Hospital | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Owings Mill 53-00 | | | |
| | | D. STREET ADDRESS (If rural, give location)
Wards Chapel Road | | | |
| 5. SEX
Male | 6. RACE
Caucasian | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)
Married | 8. DATE OF BIRTH
2/6/90 | 9. AGE (In years last birthday)
77 | 10. If Under 1 Yr. Months; Days; If Under 24 Hrs. Hours; Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Poultry raiser | | 10B. KIND OF BUSINESS OR INDUSTRY
Agriculture | | 11. BIRTH PLACE (State or foreign country)
Maryland | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
Robert Sellman | | 14. MOTHER'S MAIDEN NAME
Virginia Bailey | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
215-36-7429 | | 17. INFORMANT
Miss Bessie Sellman | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
331X1
DUE TO
Cerebro vascular accident | | 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | INTERVAL BETWEEN ONSET AND DEATH
3d | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that the (this hospital) attended the deceased from 4/19 19 67 to 4/22 19 67, that (I) was last saw the deceased alive on 4/22 19 67 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) was (did) not view the body after death. | | | | | |
| 23A. SIGNATURE
Nat E. Watson, Jr. | | | | 23B. DATE SIGNED
4/22/67 | |
| 23C. PHYSICIAN'S NAME (Type)
DR NAT E. WATSON | | | | 23D. ADDRESS
M.D. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
4-25-67 | | 24C. NAME OF CEMETERY or CREMATORY
Wards Chapel Cemetery | |
| 24D. LOCATION (City, town, or county)
Baltimore Co. | | 24E. STATE
Md. | | 24F. NAME OF REGISTRAR
Robert E. Feltner | |
| 24G. DATE REC'D BY HEALTH DEPT.
APR 28 1967 | | 24H. NAME OF REGISTRAR
Robert E. Feltner | | 24I. FUNERAL DIRECTOR
Harry W. Haight | |
| 24J. ADDRESS
Lykerville, Md. | | | | | |

Robert S. Seltman

Robert S. Seltman
Butcher and Agriculture
Male Cancer Married
Union Memorial Hospital

1145
Camps Mill
North Chapel Road

U.S.A.
Virginia Barker
Mrs. Bessie Seltman

Birth records accident 3d

Not S. Seltman Jr.

4/22

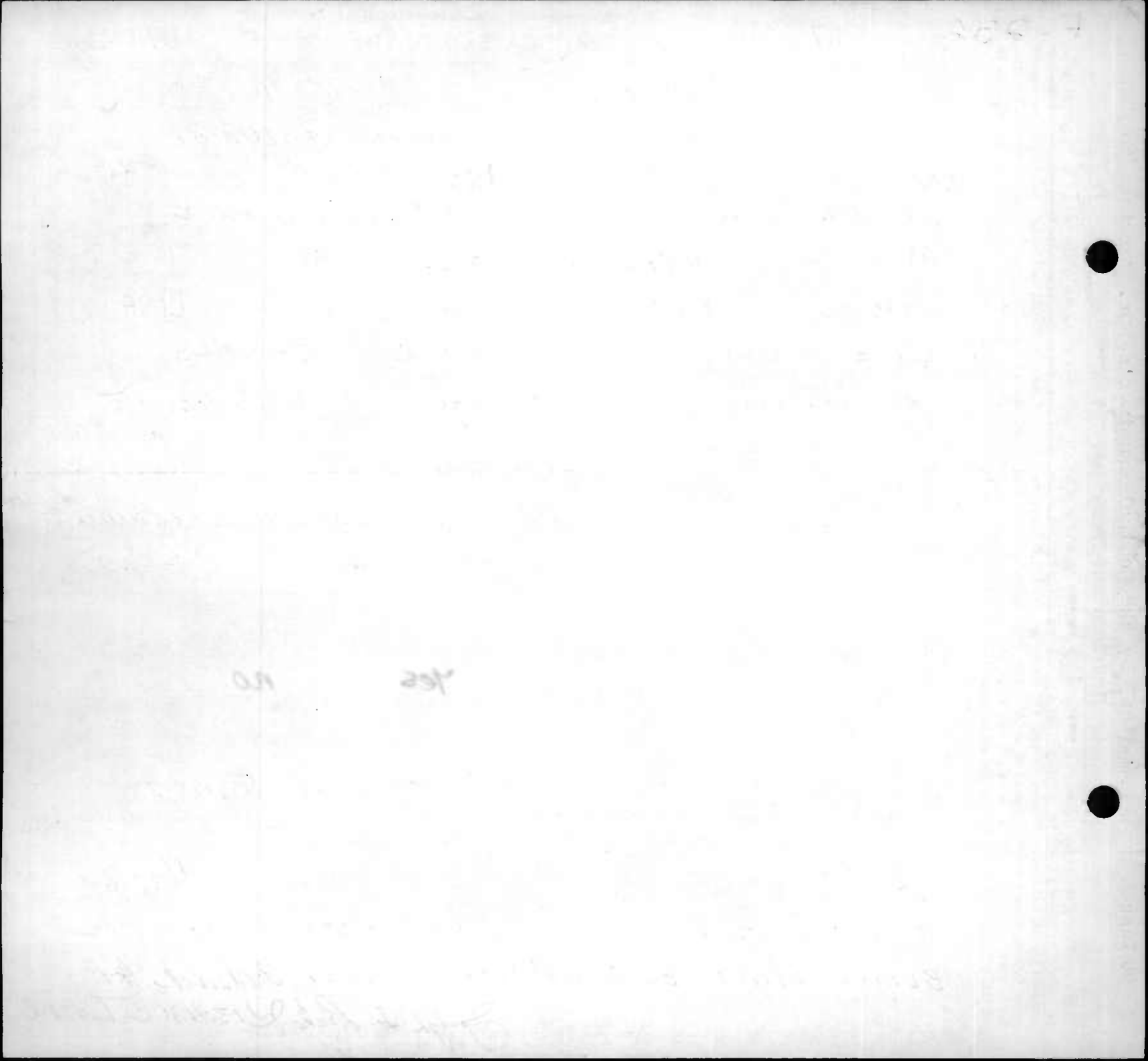
4/22

4/22/07

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

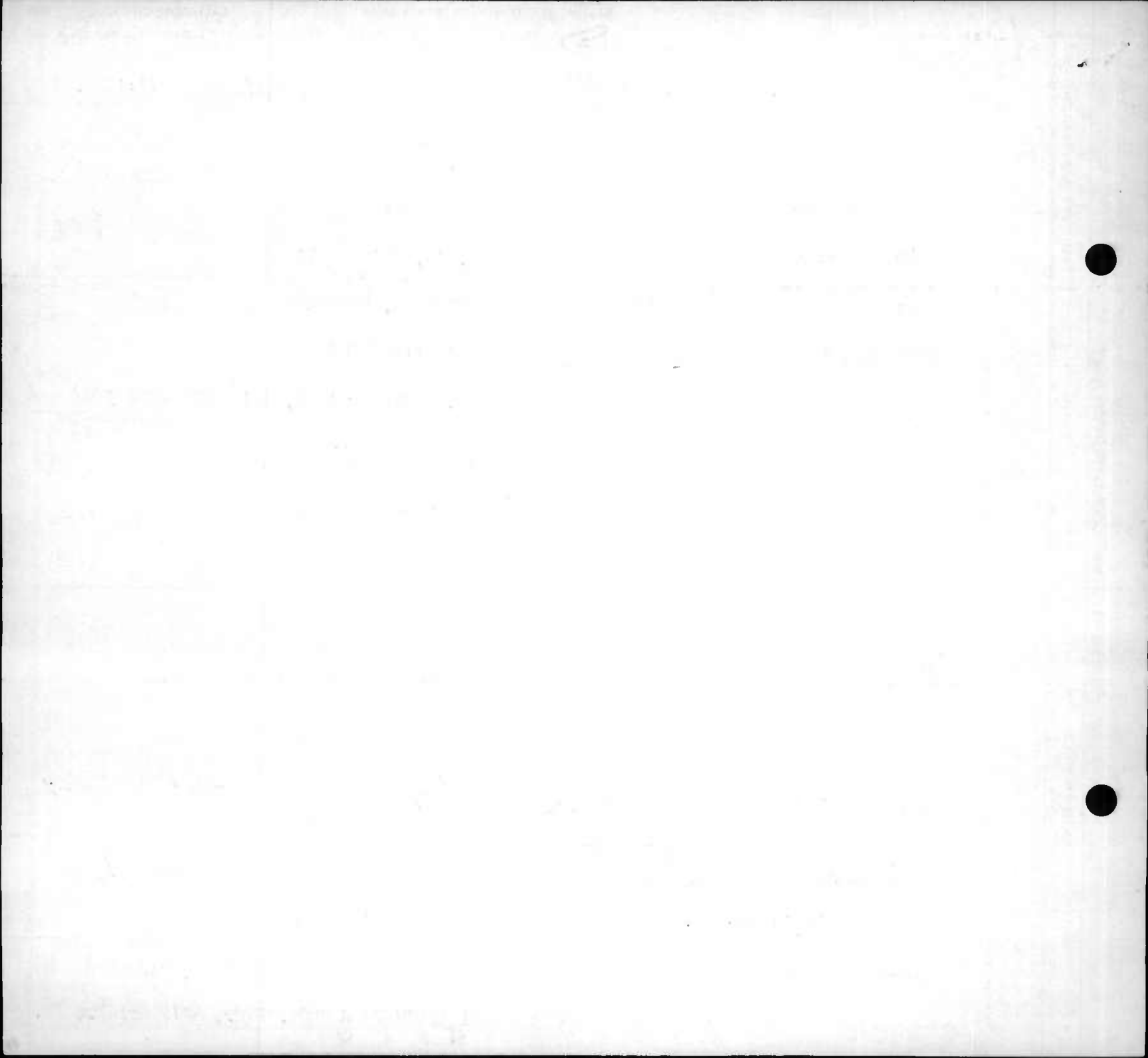
| BIRTH NO. 67 4164 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 4164 | |
|--|---------------------|--|--|---|--|
| M.E. CASE NO. | | | CERTIFICATE OF DEATH | | |
| 1. NAME OF DECEASED
(Type or Print) <i>CHARLES FOSTER</i> | | | 2. DATE AND HOUR OF DEATH
<i>4-27-67 @ 7:30 AM</i> | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)
A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<i>Home - 113 Orleans St
00 Baltimore 2, Md</i> | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<i>1113 Orleans St 5-02</i> | | |
| | | | D. STREET ADDRESS (If rural, give location)
<i>Baltimore, Missouri 2</i> | | |
| 5. SEX
<i>M</i> | 6. RACE
<i>C</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
<i>MARRIED</i> | 8. DATE OF BIRTH
<i>1/22/26</i> | 9. AGE (In years lost birthday)
<i>41</i> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Labourer</i> | | 10B. KIND OF BUSINESS OR INDUSTRY
<i>BUR HA</i> | | 11. BIRTHPLACE (State or foreign country)
<i>Maryland</i> | |
| 13. FATHER'S NAME
<i>OBIE FOSTER</i> | | 14. MOTHER'S MAIDEN NAME
<i>DIANE ENNALS</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>Yes 1944-1946 & 50-51</i> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
<i>Wife - 113 Orleans St</i> | |
| 18. <i>593X</i>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH
(A) <i>Cardiac failure</i>
DUE TO
(B) <i>Chronic renal failure - anuria</i>
DUE TO
(C) <i>hypertension</i> | | INTERVAL BETWEEN ONSET AND DEATH
<i>unknown 6 mos</i>
<i>5 yrs</i> |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
<i>2</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<i>Yes</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
White At <input type="checkbox"/> Not White At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) <i>(this hospital)</i> attended the deceased from <i>September 1967</i> to <i>April 25 1967</i> , that (I) <i>(we)</i> last saw the deceased alive on <i>April 25 1967</i> and that in (my) <i>(our)</i> opinion death occurred on the date and hour and from the causes stated above. (I) <i>(We)</i> <i>(did)</i> <i>(did not)</i> view the body after death. | | | | | |
| 23A. SIGNATURE
<i>H. W. Coussons</i> | | | | 23B. DATE SIGNED
<i>4/27/67</i> | |
| 23C. PHYSICIAN'S NAME (Type)
<i>H. W. COUSSONS</i> | | | | 23D. ADDRESS
M.D. <i>JOHNS HOPKINS HOSPITAL</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>BURIAL</i> | | 24B. DATE
<i>5/1/67</i> | | 24C. NAME OF CEMETERY or CREMATORY
<i>Balto. National</i> | |
| 24D. LOCATION (City, town, or county) (State)
<i>5501 Frederick St</i> | | 25A. DATE RECEIVED BY HEALTH DEPT.
<i>APR 26 1967</i> | | | |
| 25B. NAME OF REGISTRAR
<i>Robert E. Taylor</i> | | 25C. FUNERAL DIRECTOR
<i>Joseph L. Lock & 1304 N. Central Ave</i> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPT. | | | | 67 4165 | |
|--|--|--|--|--|--|
| CERTIFICATE OF DEATH | | | | Registered No. 67 4165 | |
| BIRTH NO. | | M.E. CASE NO. | | 2. DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED
(Type or Print) | | DR. MILTON J. WILDER | | APRIL 23, 1967 11:15 P. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
SINAI HOSPITAL | | A. STATE
MARYLAND | | | |
| (If not in hospital or institution, give street address or location) | | B. COUNTY | | | |
| 5. SEX
MALE | | 6. RACE
WHITE | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
MARRIED | |
| 8. DATE OF BIRTH
AUG. 18, 1915 | | 9. AGE (In years last birthday)
51 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
DOCTOR | |
| 11. BIRTHPLACE (State or foreign country)
BALTIMORE, MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
DAVID WILDER | |
| 14. MOTHER'S MAIDEN NAME
DENA SILVERSTEIN | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
UNKNOWN | |
| 17. INFORMANT
MRS. CLAIRE WILDER, 3412 SHELburne ROAD | | ADDRESS
#8 | | 18. CAUSE OF DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Acute myocardial infarction | | INTERVAL BETWEEN ONSET AND DEATH
0 | | 19. ANTECEDENT CAUSES | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Arteriosclerotic CV disease | | 3 years | | 20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | |
| 21A. DATE OF OPERATION | | 21B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 22A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1958 to 4/23 1967, that (I) (we) lost saw the deceased alive on 4/22 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Abraham Genecin | | | | 23B. DATE SIGNED
4/24/67 | |
| 23C. PHYSICIAN'S NAME (Type)
DR. ABRAHAM GENECIN | | | | 23D. ADDRESS
611 PARK AVENUE | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
4/26/67 | | 24C. NAME OF CEMETERY or CREMATORY
CHIZUK AMUNO (ARLINGTON) | |
| 24D. LOCATION
BALTIMORE, MARYLAND | | 25A. DATE RECEIVED BY HEALTH DEPT.
APR 28 1967 | | | |
| 25B. NAME OF REGISTRAR
Robert E. Sullivan | | 25C. FUNERAL DIRECTOR
SOL LEVINSON & BROS. INC., 6010 REIST., RD. | | | |



1
W-430

67 4166

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

67 4166

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

WILLIAM J. WILLETT

2. DATE AND HOUR PRONOUNCED DEAD

4-25-67

4:28 PM M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

00801 S. BETHEL STREET - Amb. Crew #10

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

801 S. Bethel Street 21231

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

NEVER MARRIED

8. DATE OF BIRTH

AUG. 18 187

9. AGE (In years
last birthday)

79

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

RETIRED SEAMON

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

INDIANAPOLIS INDIANA

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

UNK

14. MOTHER'S MAIDEN NAME

UNIS

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). If yes, give war or dates of service)

YES

WORLD WAR I

16. SOCIAL
SECURITY NO.

217-18-5584A

17. INFORMANT

ADDRESS

VILOA JAKUBS 801 S BETHEL STREET

18.

422.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B)
DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT NOT WHILE
WORK ☐ AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE

RUSSELL S. FISHER, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4-26-67

23A. BURIAL CREMATION,
REMOVAL (Specify).

BURIAL

23B. DATE

APR 28 1967

23C. NAME OF CEMETERY or CREMATORY

BALTIMORE NATIONAL CEM.

23D. LOCATION

(City, town, or county)

(State)

FREDERICK ROAD MD

24A. DATE REC'D BY HEALTH DEPT.

APR 28 1967

24B. NAME OF REGISTRAR

P. D. & E. Fisher, M.D.

24C. FUNERAL DIRECTOR

DIPPEL BROS INC 1800 E LOMBARD ST

ADDRESS

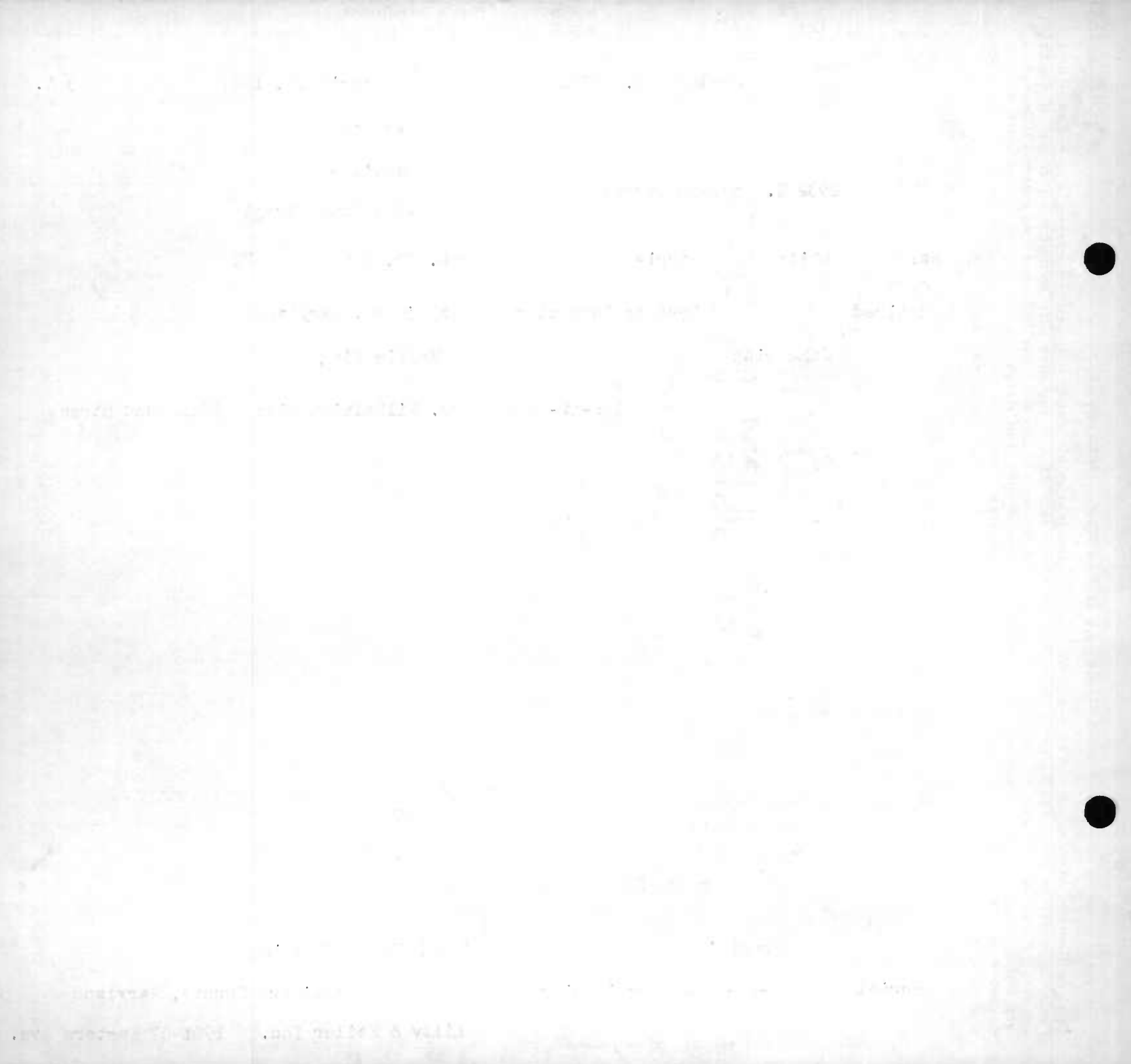
RECEIVED
FBI
JUL 10 1964

TO : DIRECTOR, FBI
FROM : SAC, NEW YORK
SUBJECT: [illegible]
RE: [illegible]

NY 100-100000-1000
NY 100-100000-1000

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | | | | | Registered No. 67 4167 | |
|--|-------------------------|--|---|--|---|---|------------------------------|
| BIRTH NO. 67 4167 | | | | | | | |
| M.E. CASE NO. | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) CHARLES H. RITZ | | | | | | 2. DATE AND HOUR OF DEATH
April 26, 1967 3 A. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
00 2932 E. Fayette Street | | | | | | A. STATE Maryland
B. COUNTY | |
| | | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | |
| | | | | | | D. STREET ADDRESS (If rural, give location)
1914 Bank Street | |
| 5. SEX
Male | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married | 8. DATE OF BIRTH
Oct. 30, 1894 | 9. AGE (In years last birthday)
72 | If Under 1 Yr. Months: Ooys: If Under 24 Hrs. Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired | | | 10B. KIND OF BUSINESS OR INDUSTRY
Customs Inspector | | 11. BIRTHPLACE (State or foreign country)
Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME
John Ritz | | | 14. MOTHER'S MAIDEN NAME
Mollie King | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO.
218-42-5044 | | 17. INFORMANT
Mrs. Wilhelmina Ritz | | |
| | | | | | ADDRESS
1914 Bank Street | | |
| 18. 332 X I CAUSE OF DEATH | | | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | (A) Cerebrovascular thrombosis | | INTERVAL BETWEEN ONSET AND DEATH
3 mo | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) Generalized arteriosclerosis | | arterio 10 yrs. | |
| | | | | (C) | | | |
| II | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 3-18 19 66 to current 19 67 , that (I) (we) last saw the deceased alive on 3-31 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
Rovetti | | | | M.O. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
4-29-67 | |
| 23C. PHYSICIAN'S NAME (Type)
Rovetti | | | | 23D. ADDRESS
M.D. Church Home & Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
4-29-1967 | | 24C. NAME of CEMETERY or CREMATORY
Druid Ridge | | 24D. LOCATION (City, town, or county) (State)
Baltimore County, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 28 1967 | | 25B. NAME OF REGISTRAR
Lilly & Zeiler Inc. | | 25C. FUNERAL DIRECTOR ADDRESS
1901-07 Eastern Ave. | | | |



F-655

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 67 4168 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 4168

M.E. CASE NO.

| | | | | | | | |
|--|--------------------|--|---|---|---|--|--|
| 1. NAME OF DECEASED
(Type or Print)
MARY OLIVE FREEMAN | | | | 2. DATE AND HOUR PRONOUNCED DEAD
4-26-67 1:00 PM M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
00 1715 DRUID HILL AVENUE | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
Maryland
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
1715 Druid Hill Avenue 21217 | | | |
| 5. SEX
Female | 6. RACE
Colored | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widowed | 8. DATE OF BIRTH
July 4, 1895 | 9. AGE (In years last birthday)
71 | 10. If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housekeeper | | 10B. KIND OF BUSINESS OR INDUSTRY
Private Family | | 11. BIRTHPLACE (State or foreign country)
Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A | |
| 13. FATHER'S NAME
Daniel E. Brown | | | 14. MOTHER'S MAIDEN NAME
Georgianna Gibson | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)
No | | | 16. SOCIAL SECURITY NO.
219-07-1058 | | 17. INFORMANT
Miss. Cleota Kelly 1715 Druid Hill Ave | | |
| 18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
422.1
Arteriosclerotic cardiovascular disease
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21E. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>
CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>
ACTUAL SIGNATURE <i>Russell S. Fisher</i> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
EXAMINER'S NAME (Type) RUSSELL S. FISHER, M.D. ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>
DATE SIGNED 4-26-67 | | | | | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 23B. DATE
4/29/67 | 23C. NAME OF CEMETERY or CREMATORY
Arbutus Memorial Park | | 23D. LOCATION (City, town, or county) (State)
Arbutus Balto Co. Md | | |
| 24A. DATE REC'D BY HEALTH DEPT.
APR 28 1967 | | 24B. NAME OF REGISTRAR
<i>Russell S. Fisher</i> | | 24C. FUNERAL DIRECTOR
Herbert E. Nutter 3035 W. North Ave | | | |

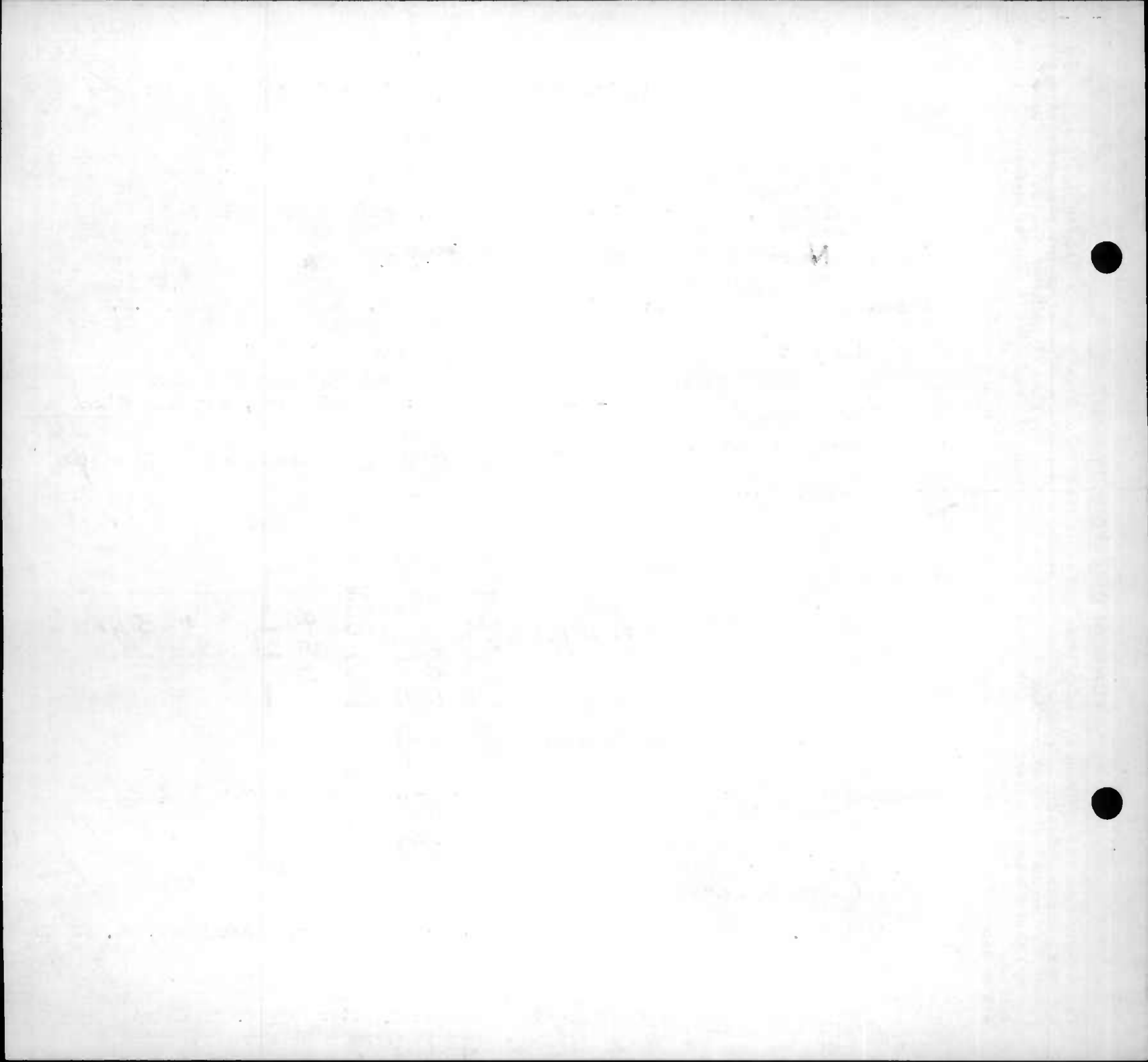
1 9 6 7 0 0 0 4 1 7 6

VALLEY FORD

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 67 4169 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | Registered No. 67 4169 | |
|---|--|---|--|--|--|--|--|--|--|
| M.E. CASE NO. | | | | 1. NAME OF DECEASED
(Type or Print) Eliza Campher (Eliza Campher) | | 2. DATE AND HOUR OF DEATH
4/25/67 | | M. 6 45/P | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | | D. STREET ADDRESS (If rural, give location)
1407 Brunt Avenue #21224 | |
| FULL NAME OF HOSPITAL OR INSTITUTION
31 Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland #21224 | | 5. SEX Female | | 6. RACE Negro | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
Widowed | | 8. DATE OF BIRTH
June 14, 1889 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Domestic | | 10B. KIND OF BUSINESS OR INDUSTRY
Private Family | | 9. AGE (In years last birthday)
77 | | 11. BIRTHPLACE (State or foreign country)
Greensboro, North Carolina | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A | |
| 13. FATHER'S NAME
John Gilchrist | | | | 14. MOTHER'S MAIDEN NAME
Maggie ? ? | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO.
214-20-5763A | | 17. INFORMANT BCH 4940 Eastern Avenue
ADDRESS RECORDS: Baltimore, Maryland #21224 | | | |
| 18. 540.01
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
GI Bleeding - stress ulcer? 2 days | | | | CAUSE OF DEATH
(A) DUE TO | | | | INTERVAL BETWEEN ONSET AND DEATH
2 days | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) DUE TO | | | | | |
| (C) DUE TO | | | | | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | Renal failure, multiple CVA's | | | | 3 yrs | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
YES | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1-18-67 to 4/25/67 and that (I) (we) last saw the deceased alive on 4/25 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
William A. Emerson | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
4/25/67 | | | |
| 23C. PHYSICIAN'S NAME (Type)
William A. Emerson | | | | 23D. ADDRESS
M.D. 4940 Eastern Avenue Baltimore, Md. #21224 | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
4/29/67 | | 24C. NAME OF CEMETERY or CREMATORY
Arbutus Memorial Park | | 24D. LOCATION (City, town, or county) (State)
Arbutus Balto Co. Md | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 28 1967 | | 25B. NAME OF REGISTRAR
Robert E. Fairbank | | 25C. FUNERAL DIRECTOR
Herbert E. Nutter | | ADDRESS
3035 W. North Ave | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. | |
|---|---------------------|--|-------------------------------------|---|---|
| BIRTH NO. 67 4170 | | CERTIFICATE OF DEATH | | Registered No. 67 4170 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) GROSS MARY S. | | 2. DATE AND HOUR OF DEATH
4/26/67 9 A M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD B. COUNTY BALTIMORE | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE | |
| FULL NAME OF HOSPITAL OR INSTITUTION
SINAI HOSP | | D. STREET ADDRESS (If rural, give location)
4000 Fallsstaff Rd | | 27-20 | |
| 5. SEX
F | 6. RACE
W | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH
10/31/99 | 9. AGE (In years last birthday)
67 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
retired | | 10B. KIND OF BUSINESS OR INDUSTRY
— | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
ABRAHAM | | 14. MOTHER'S MAIDEN NAME
Chig | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
H. Walen, M.D. | |
| ADDRESS
SINAI HOSP | | | | | |
| 18. 443X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)
Brain Stem Infarction
(A) DUE TO
H ASCVD
(B) DUE TO
Many years
(C) DUE TO | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH
5 DAYS | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
none | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
none | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 4/21 19 67 to 4/26 19 67 , that (I) (we) lost saw the deceased alive on 4/26 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Harry M. Walen | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE, SIGNED
4/26/67 | |
| 23C. PHYSICIAN'S NAME (Type)
HARRY M. WALEN | | M.D. 23D. ADDRESS
SINAI HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
4/27/1967 | | 24C. NAME of CEMETERY or CREMATORY
SOUTHERN AVE | |
| 24D. LOCATION
BALTO. | | (City, town, or county) | | (State)
MD | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 28 1967 | | 25B. NAME OF REGISTRAR
Robert E. Taylor | | 25C. FUNERAL DIRECTOR
SYLON S. LEWIS + SON, INC. - GARRISON | |
| ADDRESS
MD | | | | | |

1914

1914

1914

From 1914 to 1915
Spent 2 years in the
United States

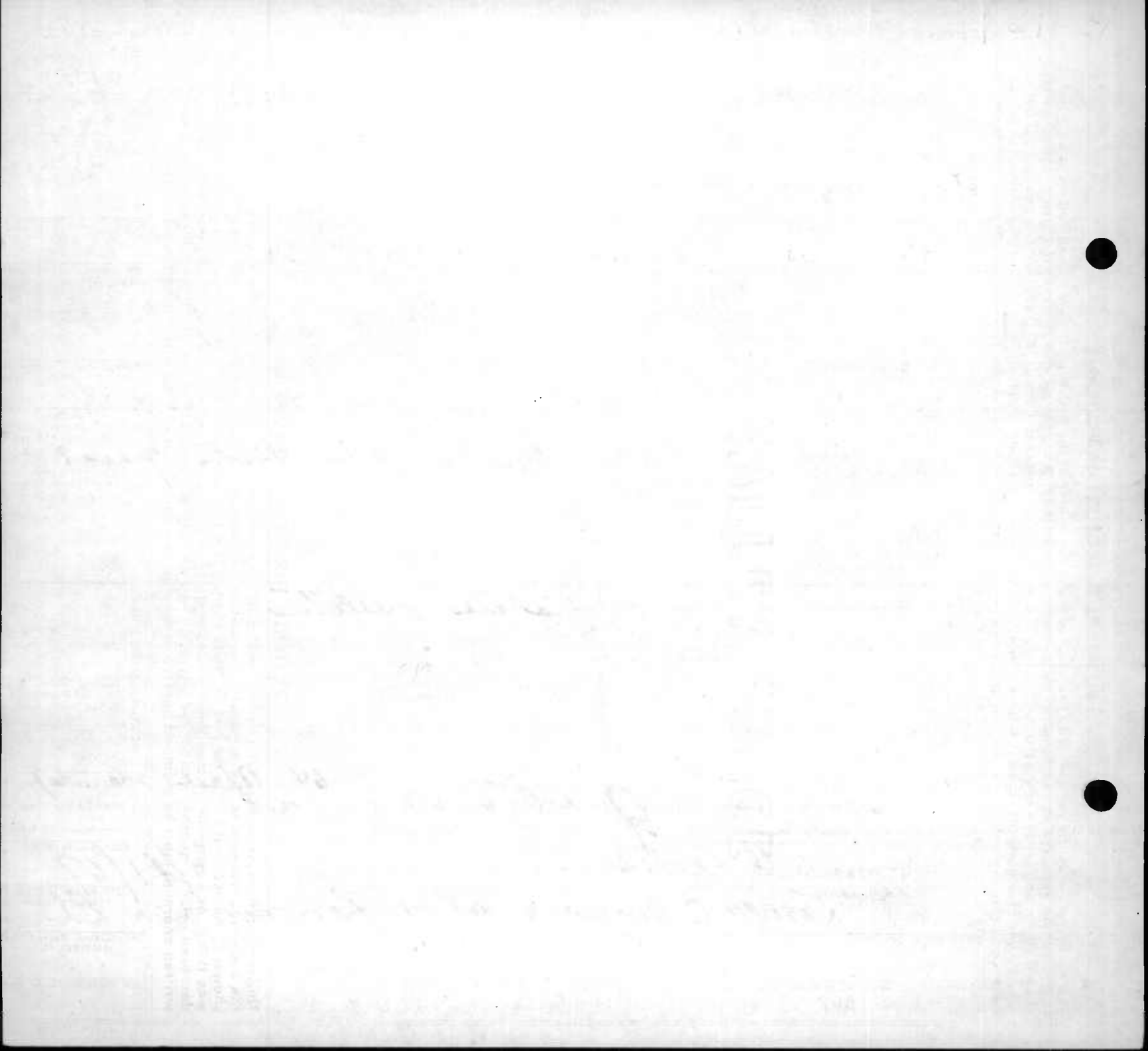
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | Registered No. <u>67 4171</u> | |
|--|---------------------|---|---------------------------------------|---|---|---|--|
| BIRTH NO. <u>67 4171</u> | | M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) <u>WILLIAM BLUMBERG</u> | | 2. DATE AND HOUR OF DEATH
<u>APRIL 26, 1967</u> <u>1 P</u> M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<u>904601 PALL MALL ROAD</u>
<u>Jewish Conv. & Nursing Home</u> | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <u>MARYLAND</u>
B. COUNTY <u>BALTIMORE</u>
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>27-16</u>
D. STREET ADDRESS (If rural, give location) <u>4601 PALL MALL ROAD</u> | | | |
| 5. SEX
<u>M</u> | 6. RACE
<u>W</u> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<u>SINGLE</u> | 8. DATE OF BIRTH
<u>10-12-1897</u> | 9. AGE (In years
last birthday)
<u>69</u> | If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>SALES MAN</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>Latvia</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>213-16-4888</u> | | 17. INFORMANT
<u>HARRY KULP</u> | | ADDRESS
<u>3708 COLLIER RD</u> | |
| 18. <u>444X 17260X</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)

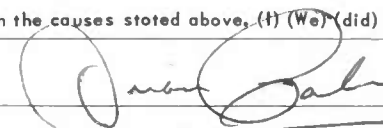
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | | | CAUSE OF DEATH
(A) <u>Hypertension, arteriosclerosis</u>
DUE TO
(B) <u>years?</u>
DUE TO
(C) | | INTERVAL BETWEEN ONSET AND DEATH | |
| | | | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
<u>Diabetes mellitus</u> | | | |
| 19A. DATE OF OPERATION
<u>D</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<u>No</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>June 1964</u> to <u>April 26 1967</u> , that (I) <u>was</u> lost saw the deceased alive on <u>June 26 1967</u> and that in <u>my</u> (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above. <u>I</u> (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
<u>Joseph C. Matchar</u> M.D. | | | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
<u>4/27/67</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>JOSEPH C. MATCHAR</u> | | | | 23D. ADDRESS
<u>6871 REISTERSTOWN RD.</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | 24B. DATE
<u>4/27/67</u> | | 24C. NAME OF CEMETERY or CREMATORY
<u>Cherry Chapel & Crematory</u> | | 24D. LOCATION (City, town, or county) (State)
<u>Randallstown Md</u> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>APR 28 1967</u> | | 25B. NAME OF REGISTRAR
<u>Robert E. Farley</u> | | 25C. FUNERAL DIRECTOR
<u>Sylvan S. Lewis & Son</u> | | ADDRESS
<u>Garrison, Md</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | | | Registered No. 67 4172 | |
|---|------------------|---|---|--|--|
| BIRTH NO. 67 4172 | | | | | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED
(Type or Print) | | GAIGALAS, ANNA Y. | | 2. DATE AND HOUR OF DEATH
APRIL 25, 1967 11:45A | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION

40 ST. AGNES HOSPITAL | | A. STATE
MARYLAND
B. COUNTY
Balt Co. | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE 53-00 | | | |
| | | D. STREET ADDRESS (If rural, give location)
5901 SUNSET AVENUE 21207 | | | |
| 5. SEX
FEMALE | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
WIDOWED | 8. DATE OF BIRTH
4/3/93 | 9. AGE (In years last birthday)
74 | 10. Under 1 Yr. Months Days
11 Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY
NONE | | 11. BIRTHPLACE (State or foreign country)
LITHUANIA | |
| 12. CITIZEN OF WHAT COUNTRY?
NOT U.S. CITIZEN | | | | | |
| 13. FATHER'S NAME
BARTHOLAMEW YAKAMICUTE (DEC'D) | | | 14. MOTHER'S MAIDEN NAME
AGOTA (DEC'D) | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NONE NONE | | 16. SOCIAL SECURITY NO.
215-01-0677 | | 17. INFORMANT
ST. AGNES HOSPITAL RECORDS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
434.1
PNEUMONIA. | | CAUSE OF DEATH
(A) DUE TO
(B) PROBABLE PULMONARY EMBOLISM -
(C) C. H. F. EMPHYSEMA - PHLEBITIS | | | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from APRIL 17 1967 to APRIL 25 1967, that (I) (we) last saw the deceased alive on APRIL 25 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
 | | | | 23B. DATE SIGNED
4/25/67 | |
| 23C. PHYSICIAN'S NAME (Type)
JUAN J. CABRERA M.D. | | | | 23D. ADDRESS
ST. AGNES HOSP; CATON & WILKENS AVES. 21229 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
April 28, 1967 | | 24C. NAME OF CEMETERY or CREMATORY
Loudon Park Cem. | |
| 24D. LOCATION
Balto. Md. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 28 1967 | | 25B. NAME OF REGISTRAR
G. Truman Schwab | | 25C. FUNERAL DIRECTOR
3512 Frederick Ave, Balto. Md. | |

10:00

APRIL 22, 1968

ST. ALBANS, VERMONT

ATTORNEY

WITNESSES

ROBERT E. WHELAN, JR.

BY

JOHN

ST. ALBANS HOSPITAL

WITNESSES

ST. ALBANS

ST. ALBANS, VERMONT

WITNESSES

WITNESSES

ST. ALBANS

(SIGNED)

WITNESSES

(SIGNED)

ST. ALBANS HOSPITAL

ST. ALBANS HOSPITAL

WITNESSES

ST. ALBANS

APRIL 22, 1968

BY

JOHN

WITNESSES

ST. ALBANS HOSPITAL

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 67 4173 | | BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | Registered No. 67 4173 | |
|---|---------------------|--|------------------------------------|---|---|
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) MUTZLER EDGAR HOWARD | | 2. DATE AND HOUR OF DEATH
APR. 26, 1967 5:50 M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FRANKLIN SQUARE HOSPITAL | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD.
B. COUNTY BALTIMORE | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location)
FRANKLIN SQUARE HOSPITAL | | D. STREET ADDRESS (If rural, give location)
3136 STAFFORD ST. | | 20-06 | |
| 5. SEX
M | 6. RACE
W | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
married | 8. DATE OF BIRTH
8/10/11 | 9. AGE (In years last birthday)
55 | If Under 1 Yr. Months: Days: Hours: Min.
If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
SWEPPER | | 10B. KIND OF BUSINESS OR INDUSTRY
Balto. City | | 11. BIRTHPLACE (State or foreign country)
Balto. Md. | |
| 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 13. FATHER'S NAME
JACOB MUTZLER | | 14. MOTHER'S MAIDEN NAME (Minnie)
ELIZABETH SCHMIDT | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
Unknown | | 17. INFORMANT Evelyn ADDRESS Md.
Mrs. Esther B. Hutzler, 3136 Stafford St. Balto. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
420.11
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Antecedent Causes
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | CAUSE OF DEATH
Acute Myocardial Infarction
EMBOLISM of CAROTID Artery
(A) DUE TO CVA
(B) DUE TO
(C) | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from March 19, 1967 to April 26, 1967 , that (I) (we) lost saw the deceased alive on April 26, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Sany Bao Ha | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
April 26 '67 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS
M.D. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
April 29, 1967 | | 24C. NAME of CEMETERY or CREMATORY
Loudon Park Cemetery | |
| 24D. LOCATION (City, town, or county) (State)
Balto. Md. | | 25A. DATE REC'D BY HEALTH DEPT.
APR 28 1967 | | 25B. NAME OF REGISTRAR
Robert E. Farber | |
| 25C. FUNERAL DIRECTOR
G. Truman Schwab | | 25D. ADDRESS
3512 Frederick Ave. Balto. Md. | | | |

(Minnie)

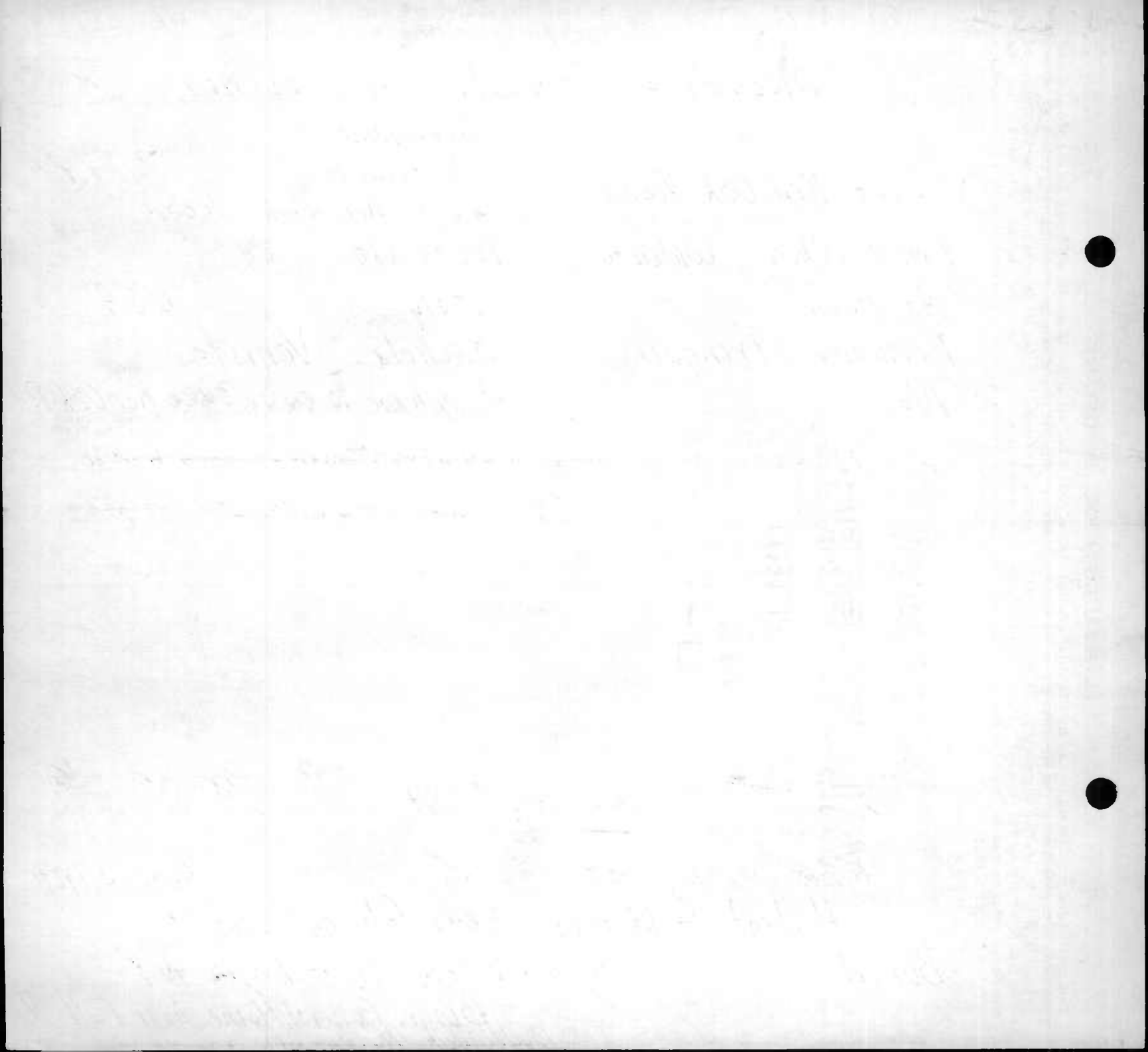
Mrs. Esther E. Butler 3136 Stafford St. Balto.
Md.

No

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 67 4174 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 4174 | |
|--|-------------------------|---|--|--|---|
| M.E. CASE NO. | | | CERTIFICATE OF DEATH | | |
| 1. NAME OF DECEASED
(Type or Print) <i>Micheline Tringeli</i> | | 2. DATE AND HOUR OF DEATH
<i>April 22 1967</i> | | | |
| 3. PLACE OF DEATH IN <i>Baltimore, Maryland</i> | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <i>Maryland</i>
B. COUNTY <i>Baltimore</i> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<i>2600 Ken Oak Road</i> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<i>Baltimore</i> | | | |
| | | D. STREET ADDRESS (If rural, give location)
<i>2600 Ken Oak Road</i> | | | |
| 5. SEX
<i>Female</i> | 6. RACE
<i>White</i> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<i>Widowed</i> | 8. DATE OF BIRTH
<i>Dec 21 1887</i> | 9. AGE (In years last birthday)
<i>79</i> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>At home</i> | | 10B. KIND OF BUSINESS OR INDUSTRY
<i>-</i> | | 11. BIRTHPLACE (State or foreign country)
<i>Italy</i> | |
| 12. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | 13. FATHER'S NAME
<i>Francesco Tringeli</i> | | 14. MOTHER'S MAIDEN NAME
<i>Rachela Veniste</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>No</i> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
<i>Josephine LOVANE</i> | |
| 18. <i>170X I</i> | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | (A) <i>Carcinomatosis</i> | | <i>6 mos.</i> | |
| ANTECEDENT CAUSES | | (B) <i>Adenocarcinoma, l. breast.</i> | | <i>3 yrs.</i> | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
<i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>Jan 7</i> 19 <i>67</i> to <i>Apr 22</i> 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>Mar 27</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<i>Herbert Goldstone M.D.</i> | | | | 23B. DATE SIGNED
<i>April 24, 1967</i> | |
| 23C. PHYSICIAN'S NAME (Type)
<i>Herbert Goldstone</i> | | | | 23D. ADDRESS
<i>3643 Glenogle Ave</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY
<i>St Raymond's Cem</i> | |
| 24D. LOCATION (City, town, or county) (State)
<i>Westchester NY</i> | | 24E. NAME OF REGISTRAR
<i>P. E. E. Talley</i> | | 24F. FUNERAL DIRECTOR
<i>Burgee Funeral Home</i> | |
| 24G. DATE REC'D BY HEALTH DEPT.
<i>APR 28 1967</i> | | 24H. ADDRESS
<i>3631 Falk Rd</i> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Certificate of Death | | Registered No. 67 4175 | |
|---|------------------|--|------------------------------------|---|----------------------------|--|-----------------------------|
| BIRTH NO. 67 4175 | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) CARRIE L. WARRENER | | 2. DATE AND HOUR OF DEATH April 23 1967 9:30 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | (If not in hospital or institution, give street address or location) | | A. STATE Maryland | | B. COUNTY | |
| 00 1203 Morling Ave | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | 13-08 | |
| | | | | D. STREET ADDRESS (If rural, give location) 1203 Morling Ave | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH Nov 7 1893 | 9. AGE (In years last birthday) 73 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress | | 10B. KIND OF BUSINESS OR INDUSTRY Uniform Mfg. | | 11. BIRTHPLACE (State or foreign country) Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Dave Pittinger | | | | 14. MOTHER'S MAIDEN NAME Laura Bowers | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 220070715 | | 17. INFORMANT Harold E. Warrenner | | ADDRESS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) | | | | (A) Acute Pulmonary Congestive Sickness | | | |
| ANTECEDENT CAUSES | | | | (B) Myocardial Infarction | | 1950 | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (C) Emphysema | | 1950 | |
| II | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1-20-1950 to April 12 1967 , that (I) (we) lost saw the deceased alive on April 11 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Lawrence J. Shimanek M.D. | | | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 4-24-67 | |
| 23C. PHYSICIAN'S NAME (Type) Lawrence Shimanek M.D. | | | | 23D. ADDRESS 3711 Falls Rd. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY Jessops' Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore County, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. APR 28 1967 | | 25B. NAME OF REGISTRAR Robert E. Fisher | | 25C. FUNERAL DIRECTOR Burges Funeral Home | | ADDRESS 3631 Falls Rd | |

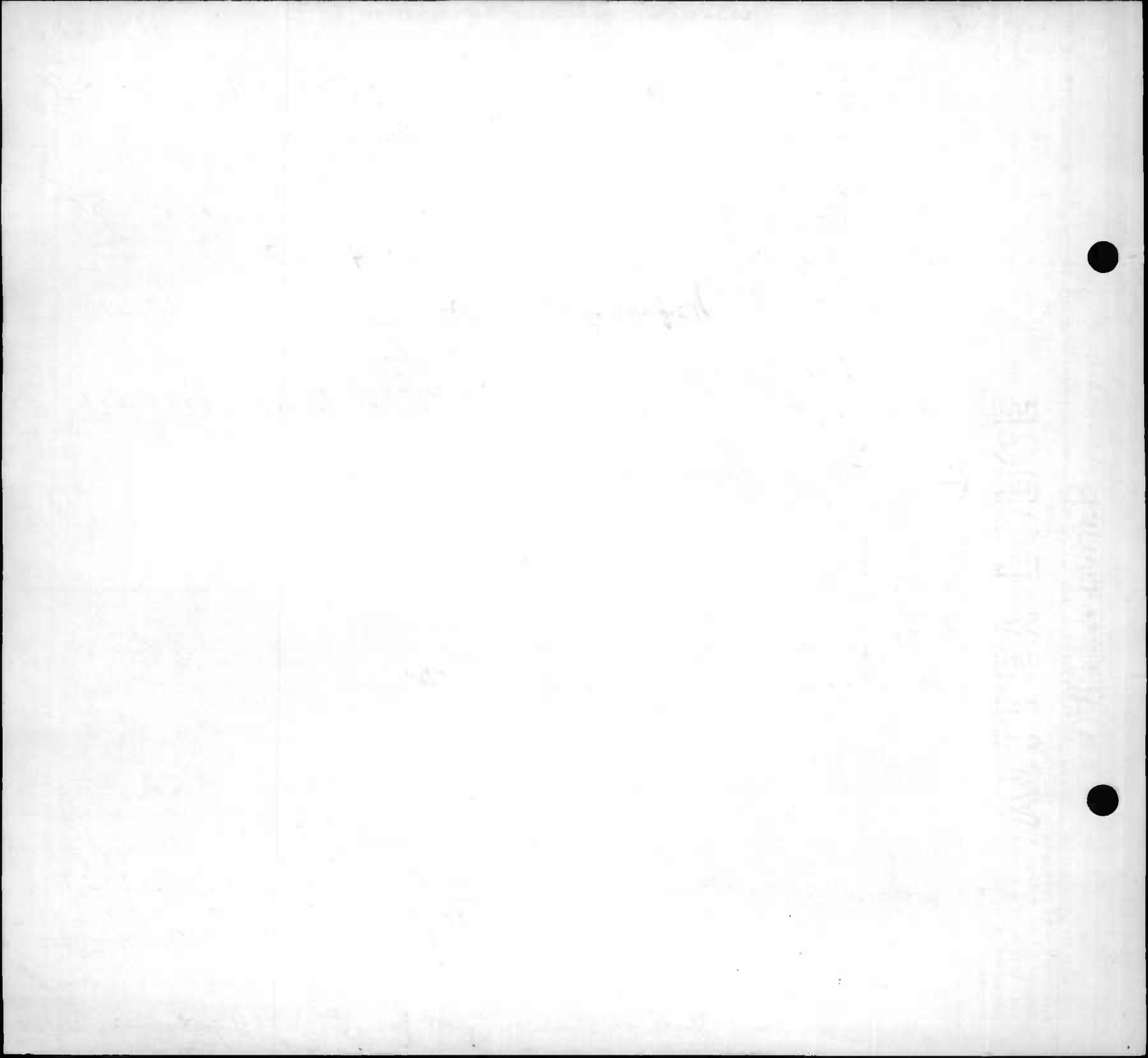
1203 No. 1, Box
F W
Graniteville, Virginia
Lester P. Hanger
No. Harold E. (Dane)

Lawrence Shinnick
3711 Falls Rd.
Bristol
County, N.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>67 4176</u> | |
|--|----------------------|---|------------------------------------|--|---|
| BIRTH NO. <u>67 4176</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type of Birth) <u>Orill-Luther M.</u> | | 2. DATE AND HOUR OF DEATH
<u>4/26/67</u> <u>10:45P.M.</u> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<u>Dukeland nursing Home</u>
<u>1501 Dukeland St.</u> | | A. STATE <u>Maryland</u>
B. COUNTY <u>Baltimore</u> | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>Baltimore</u> | | | |
| | | D. STREET ADDRESS (If rural, give location)
<u>942 W. Lombard St.</u> | | | |
| 5. SEX <u>M</u> | 6. RACE <u>White</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
<u>Widowed</u> | 8. DATE OF BIRTH
<u>1/31/84</u> | 9. AGE (In years last birthday)
<u>83</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Blacksmith</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>Manufacturing Co.</u> | | 11. BIRTHPLACE (State or foreign country)
<u>W. Virginia</u> | |
| 13. FATHER'S NAME
<u>unknown</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>NO</u> | | 16. SOCIAL SECURITY NO.
<u>216-03-4830A</u> | | 17. INFORMANT
<u>Dukeland Nursing Home</u> | |
| | | | | ADDRESS
<u>1501 Dukeland St.</u> | |
| 18. <u>422.1 I</u> | | CAUSE OF DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) <u>CHRONIC MYOCARDITIS & PULMONARY CONGESTION</u> | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) <u>ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE</u> | | | |
| | | (C) _____ | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
<u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<u>No</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>10-14</u> 19 <u>66</u> to <u>4-26</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4-26</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>Thomas W. Harris</u> | | | | 23B. DATE SIGNED
<u>4-27-67</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>THOMAS W. HARRIS</u> | | | | 23D. ADDRESS
<u>1824 W. Franklin St.</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>4/29/67</u> | | 24C. NAME OF CEMETERY or CREMATORY
<u>St. John's Cemetery</u> | |
| 24D. LOCATION (City, town, or county) (State)
<u>Baltimore, Md.</u> | | 25A. DATE REC'D BY HEALTH DEPT.
<u>APR 28 1967</u> | | | |
| 25B. NAME OF REGISTRAR
<u>John J. Covas</u> | | 25C. FUNERAL DIRECTOR
<u>John J. Covas</u> | | | |
| | | ADDRESS
<u>901 S. Hollins St.</u> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | | | | |
|---|--|---|--|--|----------------------|--|--|--|--|---|--|--|--|--|
| BIRTH NO. 67 4177 | | | | | CERTIFICATE OF DEATH | | | | | Registered No. 67 4177 | | | | |
| 1. NAME OF DECEASED (Type or Print) William Norman Foard | | | | | | | | | | 2. DATE AND HOUR OF DEATH 26 April 1967 905 p. M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MARYLAND General Hosp 48 | | | | | | | | | | A. STATE MARYLAND B. COUNTY Baltimore Co. | | | | |
| | | | | | | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Kingsville 53-00 | | | | |
| | | | | | | | | | | D. STREET ADDRESS (If rural, give location) Beachmont Farm | | | | |
| 5. SEX M | | 6. RACE W | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | | 8. DATE OF BIRTH 03-11-89 | | 9. AGE (In years last birthday) 78 | | If Under 1 Yr. Months: Days: Hours: Min. | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer | | | | 10B. KIND OF BUSINESS OR INDUSTRY Gen. Farming | | 11. BIRTHPLACE (State or foreign country) Maryland Harford Co. | | | | 12. CITIZEN OF WHAT COUNTRY? USA | | | | |
| 13. FATHER'S NAME GEORGE FOARD | | | | | | 14. MOTHER'S MAIDEN NAME ANNA STANSBURY | | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. 217-36-4529 | | 17. INFORMANT Beachmont Farm ADDRESS Aimee B. Foard Kingsville, Md 21087 | | | | | | | | |
| 18. CAUSE OF DEATH | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | | | | | | | (A) DUE TO | | | | |
| (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | | | | | | | | | (B) DUE TO | | | | |
| ANTECEDENT CAUSES | | | | | | | | | | (C) [REDACTED] | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. BENIGN PROSTATIC HYPERTROPHY POST TUR | | | | | | | | | | | | | | |
| 19A. DATE OF OPERATION 18 Apr 67 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED PROSTATIC HYPERTROPHY | | | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | 21F. HOW DID INJURY OCCUR? | | | | | | |
| 22. I certify that (1) (this hospital) attended the deceased from 11 April 1967 to 26 April 1967 , that (1) last saw the deceased alive on 26 April 1967 and that in (my) last opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | | | | | | | | | | |
| 23A. SIGNATURE Michael B. Flynn M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | | | | | | | 23B. DATE SIGNED 26 April 67 | | | | |
| 23C. PHYSICIAN'S NAME (Type) Michael B. Flynn M.D. | | | | | | 23D. ADDRESS Maryland General Hosp | | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 4/29/1967 | | 24C. NAME OF CEMETERY or CREMATORY Bethel | | 24D. LOCATION (City, town, or county) (State) Madonna, Maryland | | | | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | | | 25B. NAME OF REGISTRAR Charles E. Kurtz | | | | 25C. FUNERAL DIRECTOR ADDRESS Jarretts | | | | | | |

William F. Cook

Marshall's General Store

March 18

George Cook

March 18

Anna Starnbury

Marshall's General Store

March 18

Marshall's General Store

March 18

Marshall's General Store

FUNERAL DIRECTOR: IMPORTANT

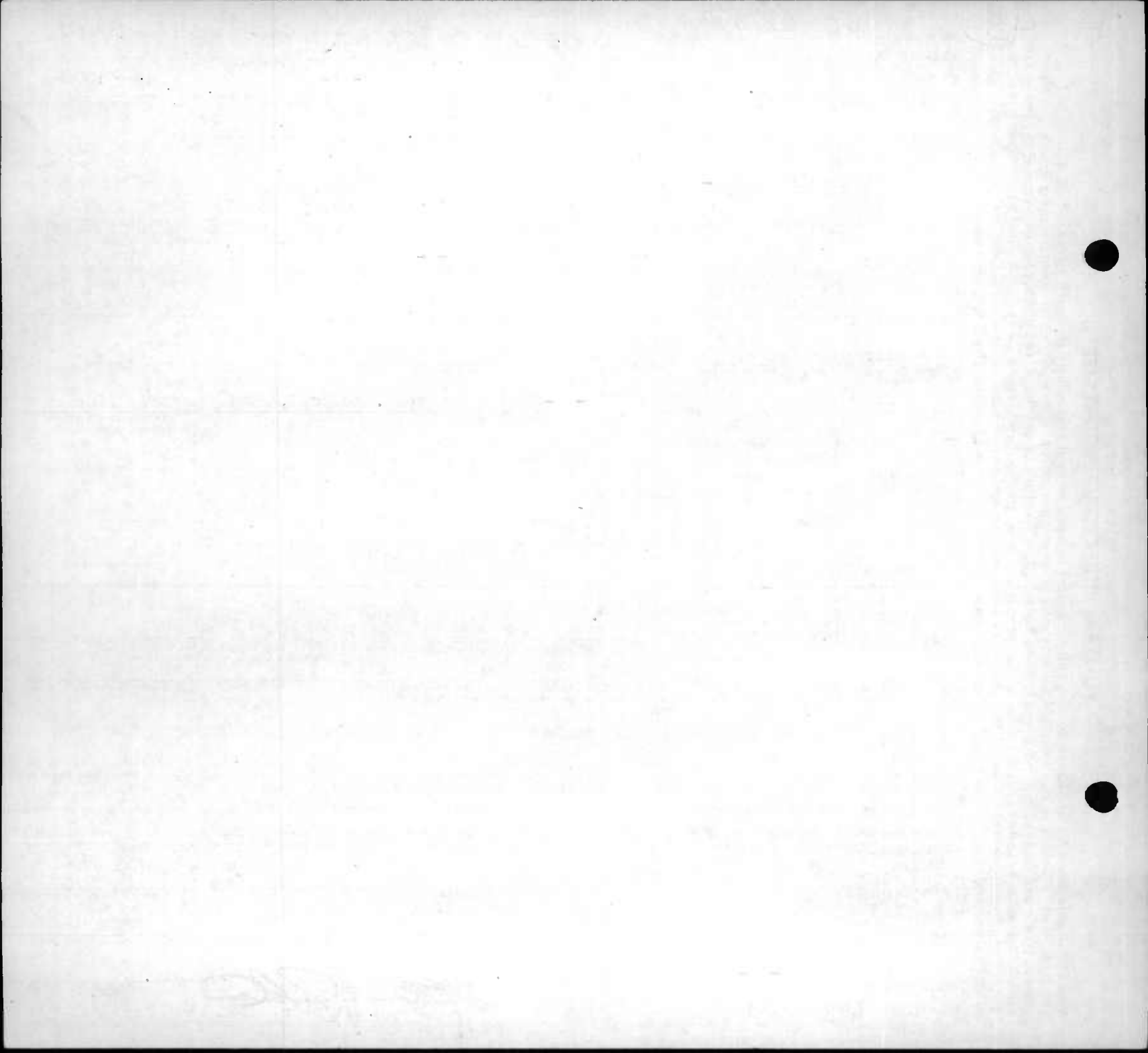
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 4178 | |
|---|-------------------------|---|------------------------------------|--|---|
| BIRTH NO. 67 4178 | | CERTIFICATE OF DEATH | | Registered No. 67 4178 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) O'HARA, John Joseph | | 2. DATE AND HOUR OF DEATH
April 26, 1967 8:30 P M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Baltimore | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
27 Veterans Administration Hospital
3900 Loch Raven Blvd.
Baltimore, Maryland 21218 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
3125 Dillon Street | | | |
| 5. SEX
Male | 6. RACE
White | 7. MARRIED, NEVER MARRIED
Married | 8. DATE OF BIRTH
8/18/17 | 9. AGE (In years last birthday)
49 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Elect. Inspector | | 10B. KIND OF BUSINESS OR INDUSTRY
Balto. City | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
John Joseph O'Hara Sr. | | | |
| 14. MOTHER'S MAIDEN NAME
Sarah Lauretta Over | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
Yes 8-11-42 to 11-13-45 | | | |
| 16. SOCIAL SECURITY NO.
212-05-7652 | | 17. INFORMANT Records ADDRESS
V.A. Hospital Baltimore, Md. 21218 | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
I
Carcinomatosis | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
Bronchogenic Carcinoma of Right Upper Lobe. | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that X (this hospital) attended the deceased from March 1, 1967 to April 26, 1967 , that X (we) last saw the deceased alive on April 26, 1967 and that in our (our) opinion death occurred on the date and hour and from the causes stated above. X (We) (did) not view the body after death. | | | | | |
| 23A. SIGNATURE
Victor J. Borges | | | | 23B. DATE SIGNED
4/26/67 | |
| 23C. PHYSICIAN'S NAME (Type)
Victor J. Borges | | 23D. ADDRESS
3900 Loch Raven Blvd.
Baltimore, Md. 21218 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
5/1/67 | | 24C. NAME OF CEMETERY OR CREMATORY
Baltimore National Cemetery | |
| 24D. LOCATION
Baltimore, Maryland | | 25A. DATE REC'D BY HEALTH DEPT.
APR 28 1967 | | | |
| 25B. NAME OF REGISTRAR
Robert E. Taylor | | 25C. FUNERAL DIRECTOR
John J. Duda Inc. 2829 Hudson St. Balto. Md | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | Registered No. 67 4179 | |
|--|-------------------------|--|---|--|---|--|---|--|---------------------------------------|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| BIRTH NO. 67 4179 | | | | | | | | | | | |
| M.E. CASE NO. | | | | | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) Isabel M. Holland | | | | | 2. DATE AND HOUR OF DEATH
4-22-67 3:00 P M. | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY Baltimore Co. | | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
90 House in Pines - Belvedere | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore 34 53-00 | | | | | | |
| (If not in hospital or institution, give street address or location) | | | | | D. STREET ADDRESS (If rural, give location)
1812 Dunwoody Circle | | | | | | |
| 5. SEX
Female | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widowed | 8. DATE OF BIRTH
9-1-84 | 9. AGE (In years last birthday)
82 | If Under 1 Yr. Months: Days: Hours: Min. | | | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | | 10B. KIND OF BUSINESS OR INDUSTRY
Own Home | | 11. BIRTHPLACE (State or foreign country)
Virginia | | | 12. CITIZEN OF WHAT COUNTRY?
USA | | | |
| 13. FATHER'S NAME
George Montgomery | | | | | 14. MOTHER'S MAIDEN NAME
Helen Redford | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | | | 16. SOCIAL SECURITY NO.
223-09-2878 | | 17. INFORMANT ADDRESS
Howard H. Holland, 1812 Dunwoody Circle | | | | |
| 18. 4 22 1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)
Congestive heart failure
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Arteriosclerotic C.V. disease | | | | | | | | | | CAUSE OF DEATH
INTERVAL BETWEEN ONSET AND DEATH | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | |
| 19A. DATE OF OPERATION
0 | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE
George C. Schwary | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | 23B. DATE SIGNED
22 April 67 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | | 23D. ADDRESS
M.D. | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | | 24B. DATE
4-24-67 | | 24C. NAME OF CEMETERY or CREMATORY
Forest Lawn Cem. | | | 24D. LOCATION (City, town, or county) (State)
Richmond Virginia. | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 28 1967 | | | 25B. NAME OF REGISTRAR
W. E. Johnson | | | 25C. FUNERAL DIRECTOR
William E. Johnson | | | ADDRESS
8521 Loch Raven Blv | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|-----------------------------|--|---|---|---|
| 67-08148
BIRTH NO. 67 4180 | | BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | Registered No. 67 4180 | |
| M.E. CASE NO.
1. NAME OF DECEASED
(Type or Print) FRANK HARMON EPPLER, JR. | | | 2. DATE AND HOUR OF DEATH
4-26-67 5:35 P.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
THE JOHNS HOPKINS HOSPITAL | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE
D. STREET ADDRESS (If rural, give location) 403 N. CHESTER ST. | | |
| 5. SEX
MALE | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
NEVER MARRIED | 8. DATE OF BIRTH
4-23-67 | 9. AGE (In years last birthday)
3 | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME
FRANK HARMON EPPLER | | | 14. MOTHER'S MAIDEN NAME
HELEN L. CARMAN | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT | | ADDRESS |
| 18. 77351
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osteonia, etc. It means the disease, injury or complication which caused death.)
NEURALGIC MEMBRANE DISEASE
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
PREMATURITY | | | CAUSE OF DEATH
(A) NEURALGIC MEMBRANE DISEASE
DUE TO
(B) PREMATURITY
DUE TO
(C) | | INTERVAL BETWEEN ONSET AND DEATH
3 DAYS |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
2/26/67 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
YES | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
NO |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from BIRTH 19 to APRIL 26 1967 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on April 26 1967 and that in (my) our opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did) view the body after death. | | | | | |
| 23A. SIGNATURE
Joseph M. Almand, Jr. M.D. | | | | 23B. DATE SIGNED
26 April 1967 | |
| 23C. PHYSICIAN'S NAME (Type)
JOSEPH M. ALMAND, JR. | | 23D. ADDRESS
THE JOHNS HOPKINS HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Cremation | 24B. DATE
4/27/67 | 24C. NAME OF CEMETERY or CREMATORY
The Johns Hopkins Hosp. | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 28 1967 | | 25B. NAME OF REGISTRAR
Robert E. Taylor | | 25C. FUNERAL DIRECTOR
HOSPITAL DISPOSAL | |

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THE NEW YORK PUBLIC LIBRARY

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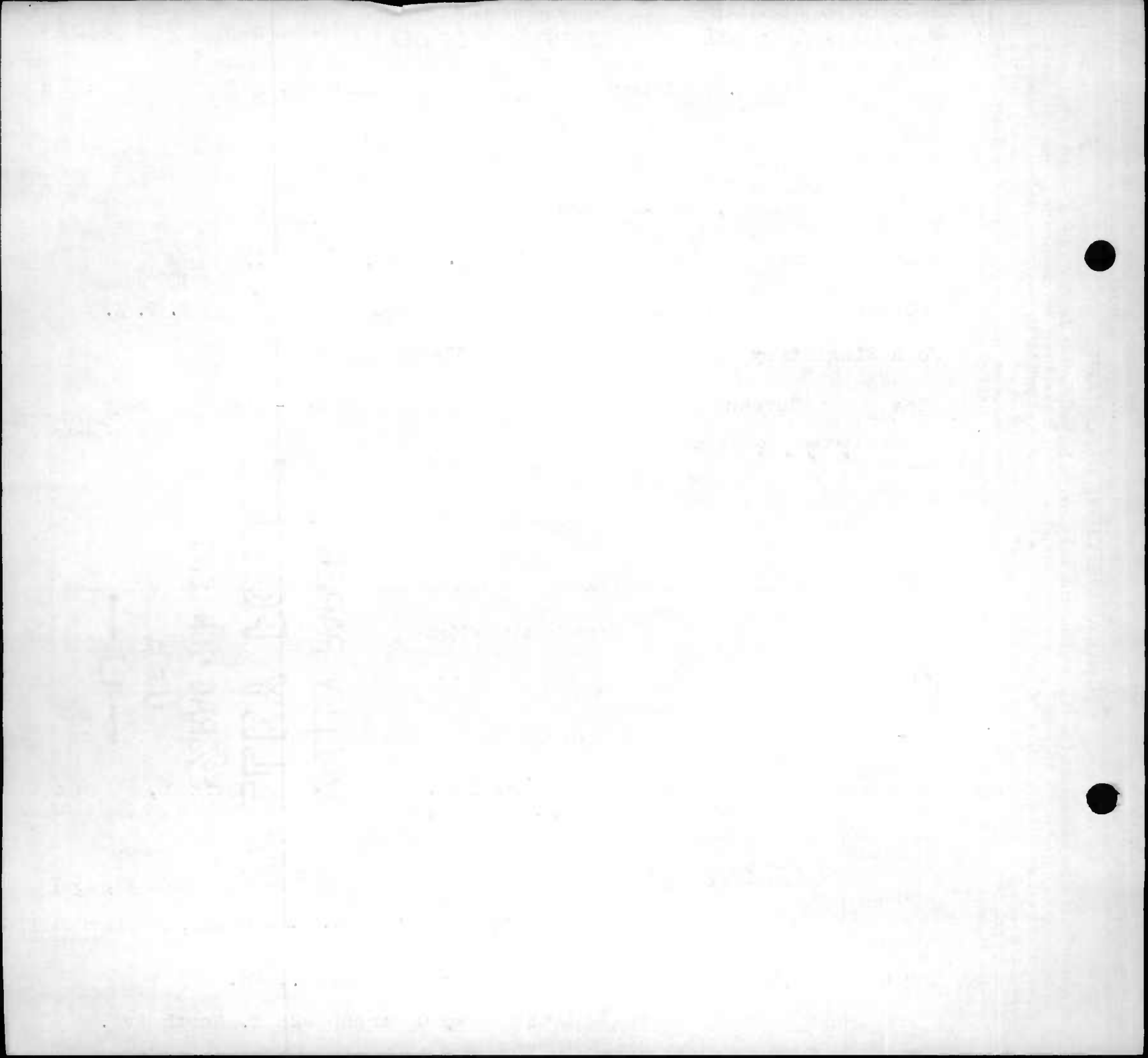
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 4181 | |
|--|-------------------------|--|---|--|--|
| BIRTH NO. 67 4181 | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED
(Type or Print) Calvin R. Singletary | | | 2. DATE AND HOUR OF DEATH
April 26, 1967 8:30 p.m. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
39 Provident Hospital
1514 Division Street
Baltimore, Maryland 21217 | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Baltimore
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1625 Brunt Street | | |
| 5. SEX
Male | 6. RACE
Negro | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
Married | 8. DATE OF BIRTH
Sept. 20, 1933 | 9. AGE (In years last birthday)
33 | If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Laborer | | | 10B. KIND OF BUSINESS OR INDUSTRY
Construction | | 11. BIRTHPLACE (State or foreign country)
Maryland |
| 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | | | 13. FATHER'S NAME
John Singletary | | |
| 14. MOTHER'S MAIDEN NAME
Gladys Horne | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
Yes Korean | | |
| 16. SOCIAL SECURITY NO. | | | 17. INFORMANT
Geraldine Singletary-wife | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
581.1 I
CAUSE OF DEATH
(A) Acute anemia
DUE TO
(B) Bleeding for esophageal varices
DUE TO
(C) Cirrhosis of the liver

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Chronic alcoholism | | | 19. DATE OF OPERATION
0 | | |
| 20. DATE OF OPERATION
0 | | | 21. CONDITION FOR WHICH OPERATION WAS PERFORMED
no | | |
| 22. I certify that (I) (this hospital) attended the deceased from April 26, 1967 to April 26, 1967 , that (I) (we) lost saw the deceased alive on April 26, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | 23. SIGNATURE
Lizarazo
M.D. <input type="checkbox"/> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | |
| 24. SIGNATURE
Lizarazo | | | 25. DATE SIGNED
April 27, 1967 | | |
| 26. PHYSICIAN'S NAME (Type)
Lizarazo | | | 27. ADDRESS
M.D. 1514 Division Street-Baltimore, Maryland 21217 | | |
| 28. BURIAL CREMATION, REMOVAL (Specify)
Burial | | | 29. DATE
5/2/67 | | |
| 30. NAME OF CEMETERY or CREMATORY
Mt Auburn Cemetery | | | 31. LOCATION (City, town, or county) (State)
Balto., Md. | | |
| 32. DATE REC'D BY HEALTH DEPT. | | | 33. NAME OF REGISTRAR
Wm C March | | |
| 34. DATE REC'D BY HEALTH DEPT. | | | 35. FUNERAL DIRECTOR
928 E. North Ave. | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | Registered No. 67 4182 | |
|---|------------------|---|---------------------------------|--|---|--|---|--|--|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| BIRTH NO. 67 4182 | | | | | | | | | | | |
| M.E. CASE NO. | | | | | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) ROSE MEIER | | | | 2. DATE AND HOUR OF DEATH
April 27, 1967. 7 ⁵⁰ A.M. | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE Md. B. COUNTY | | | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
GOULD CONVALESCARIUM
90 | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE 15-04 | | | | | | | |
| | | | | D. STREET ADDRESS (If rural, give location)
2134 HERBERT ST. | | | | | | | |
| 5. SEX
FEMALE | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
WIDOWED | 8. DATE OF BIRTH
JULY 5 1878 | 9. AGE (In years last birthday)
88 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWIFE | | 11. BIRTHPLACE (State or foreign country)
NEW YORK | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | |
| 13. FATHER'S NAME
FREDERICK FABIG | | | | 14. MOTHER'S MAIDEN NAME
EMMA ? | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | | | 16. SOCIAL SECURITY NO.
217-32-8351D | | | | 17. INFORMANT
MRS. LOUISA E. MALKUS 5700 EMELIA AVE. | | | |
| 18. 4-20-1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
CAUSE OF DEATH
(A) DUE TO Coronary artery disease ?
Cerebral arteriosclerosis ?
(B) DUE TO Blind - cataracts ?
(C) Hypertrophic arthritis ?
INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | |
| 19A. DATE OF OPERATION
0 | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from June 19 65 to April 27 19 67, that (I) (we) last saw the deceased alive on April 26 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE
Louis F. Klimes | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | | 23B. DATE SIGNED
April 28, 1967 | | | |
| 23C. PHYSICIAN'S NAME (Type)
LOUIS F. KLIMES | | | | 23D. ADDRESS
M.D. 2623 E. MONUMENT ST. | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
5/1/67 | | 24C. NAME OF CEMETERY or CREMATORY
LORRAINE PK. CEMETERY | | | | 24D. LOCATION (City, town, or county) (State)
BALTIMORE, MD. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | | | 25B. NAME OF REGISTRAR | | | | 25C. FUNERAL DIRECTOR
LEONARD J. RUCK, INC. BALTO. MD. 21204 | | | |

13A 200001

13A 200001



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|-------------------------|--|-----------------------------------|--|---|
| 67 4183 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 4183 | |
| CERTIFICATE OF DEATH | | | | | |
| 1. NAME OF DECEASED
(Type or Print) <u>Mabel JEAN MAUDE PROUD</u> | | 2. DATE AND HOUR OF DEATH
<u>April 27, 1967 8:00 A.M.</u> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<u>Union Memorial Hospital 44</u> | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE <u>MARYLAND</u>
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>BALTIMORE 21213</u>
D. STREET ADDRESS (If rural, give location)
<u>3200 RAVENWOOD ROAD</u> | | | |
| 5. SEX
<u>FEMALE</u> | 6. RACE
<u>WHITE</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
<u>MARRIED</u> | 8. DATE OF BIRTH
<u>5/1/01</u> | 9. AGE (In years last birthday)
<u>65</u> | If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>HOUSE WIFE</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>PENNSYLVANIA</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>YES USA</u> | | 13. FATHER'S NAME
<u>George PUNCHIOUS</u> | | 14. MOTHER'S MAIDEN NAME
<u>Maude Straw</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>217-22-7241</u> | | 17. INFORMANT ADDRESS
<u>Mr. George Proud (Same)</u> | |
| 18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
<u>BILATERAL PNEUMONIA M.N.</u>
INTERVAL BETWEEN ONSET AND DEATH
<u>W.N.</u> | | | | | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
<u>II</u> | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
<u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<u>Yes</u> | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSE OF DEATH?
<u>YES</u> | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>April 20</u> 19 <u>67</u> to <u>April 27</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>April 27</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>James W. Carty, Jr.</u> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
<u>4/27/67</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>James W. Carty Jr.</u> | | 23D. ADDRESS
<u>Union Memorial Hospital</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>5/1/67</u> | | 24C. NAME OF CEMETERY or CREMATORY
<u>Gardens of Faith Cem.</u> | |
| 24D. LOCATION (City, town, or county) (State)
<u>Baltimore, Md.</u> | | 25A. DATE REC'D BY HEALTH DEPT.
<u>APR 28 1967</u> | | | |
| 25B. NAME OF REGISTRAR
<u>LEONARD J. RUCK</u> | | 25C. FUNERAL DIRECTOR ADDRESS
<u>Leonard J. Ruck, Inc. Balto. Md. 21214</u> | | | |

1900

Union Mutual Life

Female White

Insurance

Policy No.

10

James W. Smith

Apr. 22

10

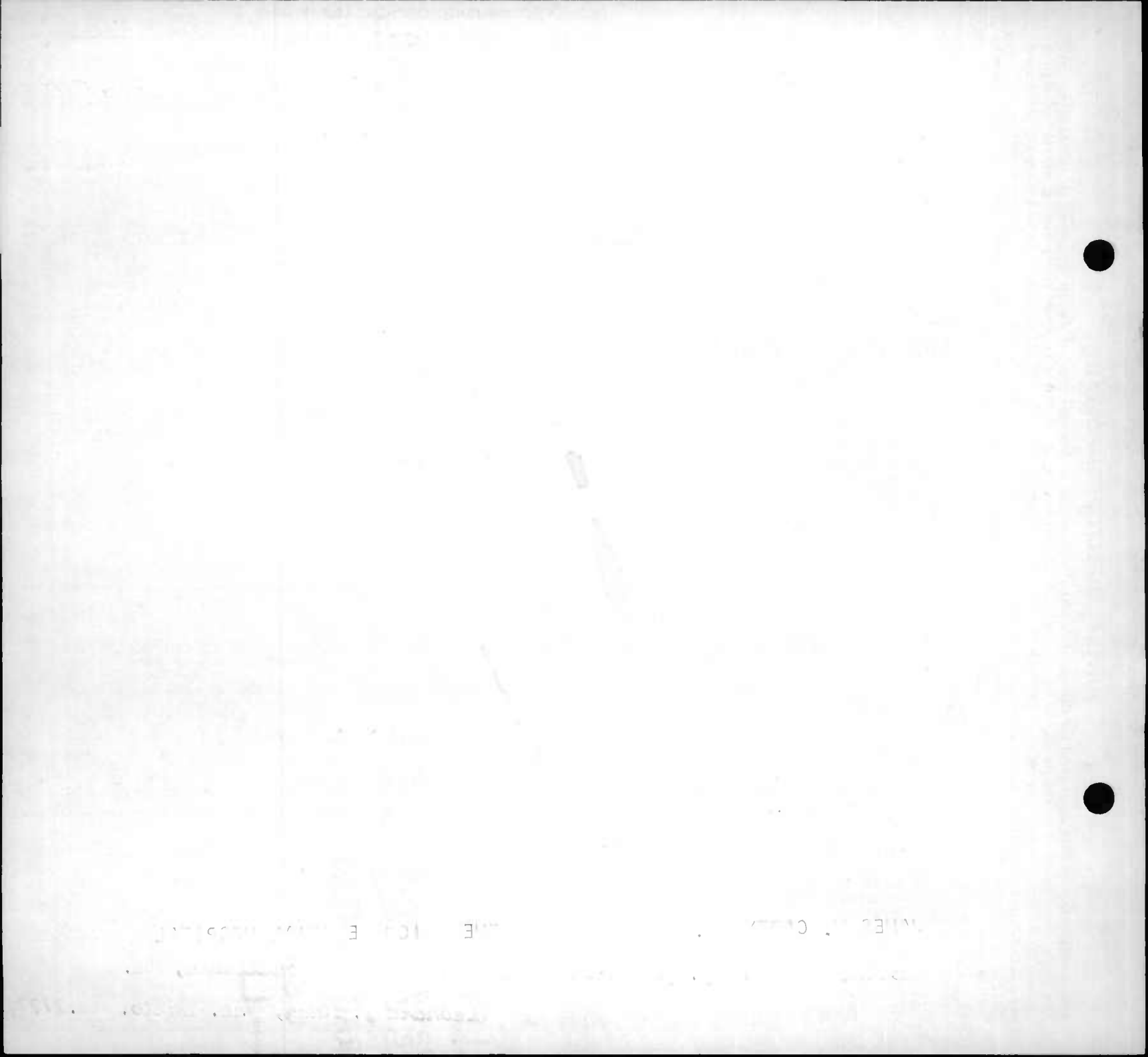
Union Mutual Life

Apr. 22

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

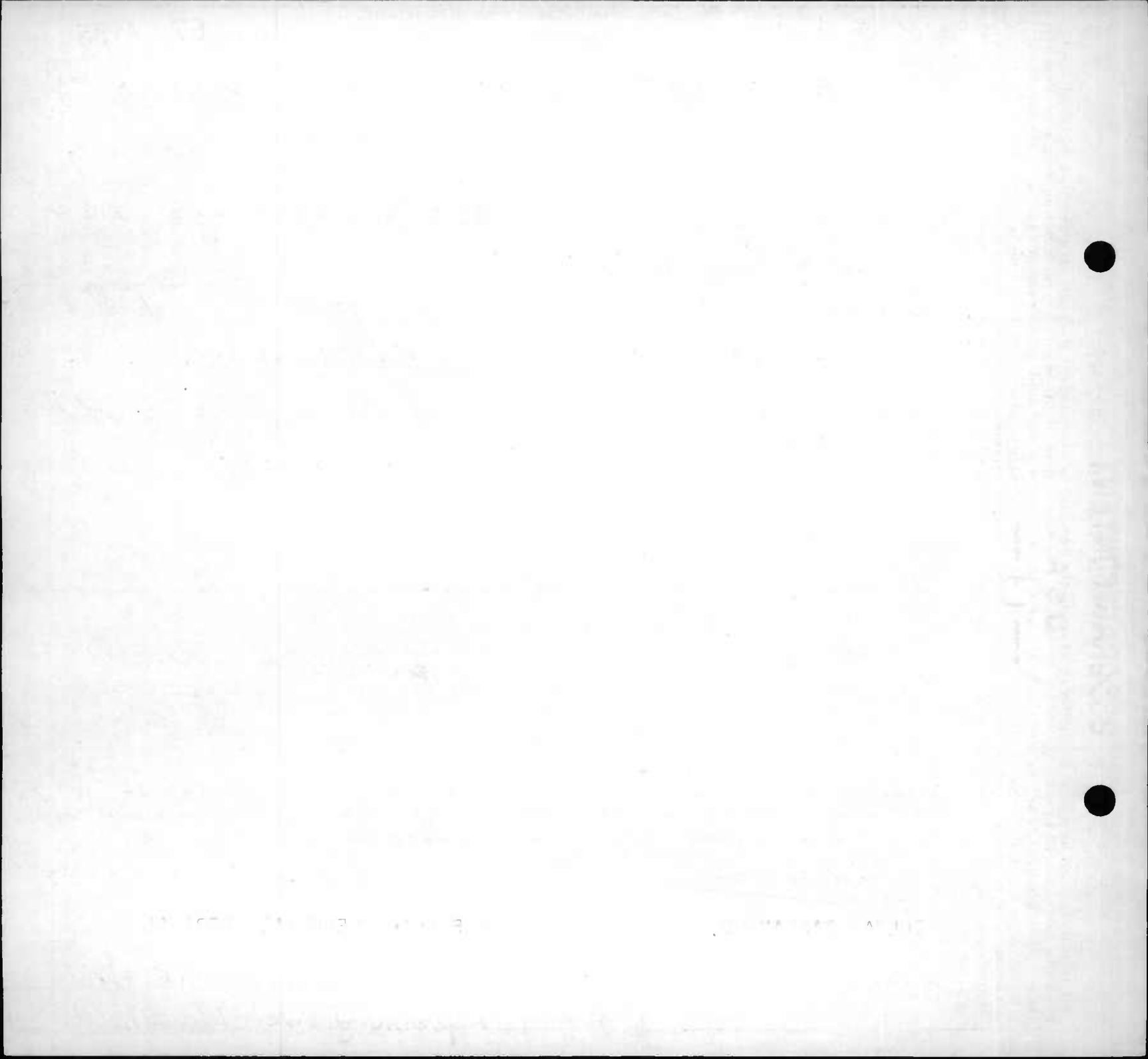
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 4184 | |
|---|------------------|--|------------------------------|--|--|
| BIRTH NO. 67 4184 | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) Rita Fowle Clark | | 2. DATE AND HOUR OF DEATH
4/27/67 3:45 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
44 Union Memorial Hosp. | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore 27-06 | | | |
| D. STREET ADDRESS (If rural, give location)
5308 Tramore Road | | | | | |
| 5. SEX
F | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH
12-05-80 | 9. AGE (In years last birthday)
86 | 10. Under 1 Yr. Months Days Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Florist (Retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 13. FATHER'S NAME
Agusta B. Clark | | 12. CITIZEN OF WHAT COUNTRY?
America | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
213-48-3118J1 | | 17. INFORMANT
Roland Clark Nephew | |
| 18. 493X1 | | CAUSE OF DEATH | | ADDRESS
4407 Arabia Ave Baltimore, MD | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenio, etc. It means the disease, injury or complication which caused death.)
Pneumonia | | (A) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH
3 days | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO | | | |
| (C) DUE TO | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 4/27 1967 to 4/27 1967, that (I) (we) last saw the deceased alive on 4/27 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
James W. Carty Jr. | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
4/27/67 | |
| 23C. PHYSICIAN'S NAME (Type)
JAMES W. CARTY MD. | | 23D. ADDRESS
THE UNION MEMORIAL HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
5/1/67 | | 24C. NAME OF CEMETERY or CREMATORY
Greenmount Cemetery | |
| 24D. LOCATION (City, town, or county) (State)
Baltimore, Md. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 28 1967 | | 25B. NAME OF REGISTRAR
R. G. E. Taylor | | 25C. FUNERAL DIRECTOR
Leonard J. Ruck, Inc. Balto. Md. 21214 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | Registered No. <u>67 4185</u> | |
|---|---------------------|---|-------------------------------------|--|----------------------------|--|-----------------------------|
| BIRTH NO. <u>67 4185</u> | | | | | | | |
| M.E. CASE NO. | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) <u>ELIZABETH GUYAS</u> | | 2. DATE AND HOUR OF DEATH
<u>April 26 1967 5²⁰ P. M.</u> | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <u>MARYLAND</u>
B. COUNTY <u>BALTIMORE</u> | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>44 UNION MEMORIAL Hospital</u> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>BALTIMORE</u> | | | | | |
| | | D. STREET ADDRESS (If rural, give location)
<u>3319 RUECKERT AVE 21214</u> | | | | | |
| 5. SEX
<u>F</u> | 6. RACE
<u>W</u> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<u>WIDOWED</u> | 8. DATE OF BIRTH
<u>10-28-98</u> | 9. AGE (In years last birthday)
<u>68</u> | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>HOUSEWIFE</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>NEW YORK</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U. S. A.</u> | |
| 13. FATHER'S NAME
<u>SAMUEL SPRINGER</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>BARBARA KER KESZ</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>196-18-1300</u> | | 17. INFORMANT ADDRESS
<u>ROBERT GUYAS, 3723 EVERGREEN AVE.</u> | | | |
| 18. <u>420.1 I</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
<u>MYOCARDIAL INFARCTION</u> | | CAUSE OF DEATH | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) <u>MYOCARDIAL INFARCTION</u> | | | | | |
| | | (B) <u>DUE TO</u> | | | | | |
| | | (C) <u>DUE TO</u> | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION
<u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<u>NO</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>04-25-67</u> 19 to <u>04-26</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>04-26</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
<u>Zoltan Zarday</u> M.D. | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
<u>04-26-67</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>ZOLTAN ZARDAY MD.</u> | | | | 23D. ADDRESS
M.D. <u>THE UNION MEMORIAL HOSPITAL</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | 24B. DATE
<u>4/29/67</u> | | 24C. NAME OF CEMETERY or CREMATORY
<u>MORELAND MEM. CEM.</u> | | 24D. LOCATION (City, town, or county) (State)
<u>BALTIMORE, MD.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>APR 28 1967</u> | | 25B. NAME OF REGISTRAR
<u>Robert E. [Signature]</u> | | 25C. FUNERAL DIRECTOR
<u>LEONARD J. RUCK, INC.</u> | | ADDRESS
<u>BALTO. MD. 21214</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|-------------------------|---|--|--|---|
| BIRTH NO. 67 4186 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 4186 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) Edna M. Stevenson | | 2. DATE AND HOUR OF DEATH
April 26, 1967. 11 P.M. M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
1602 Northwick Road | | A. STATE Md.
B. COUNTY | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore 21218 27-09 | | | |
| | | D. STREET ADDRESS (If rural, give location)
1602 Northwick Road | | | |
| 5. SEX
Female | 6. RACE
White | 7. MARRIED, NEVER MARRIED
Married | 8. DATE OF BIRTH
Feb. 10, 1906 | 9. AGE (In years last birthday)
61 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 13. FATHER'S NAME
Harry Schultheis | | 14. MOTHER'S MAIDEN NAME
Addie Borchers | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Mr. J.K. Stevenson | |
| | | | | ADDRESS
(Same) | |
| 18. 420.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Acute Coronary Occlusion
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
Acute Coronary Occlusion
(A) DUE TO
arteriosclerosis
(B) DUE TO
Cardio-vascular disease
(C) | | INTERVAL BETWEEN ONSET AND DEATH
1 day 5 years. | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
no | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan 23 65 19 to April 26 19 67 , that (I) (was) last saw the deceased alive on April 26 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
George Sawyer | | | | 23B. DATE SIGNED
Apr 28 67 | |
| 23C. PHYSICIAN'S NAME (Type)
GEORGE SAWYER | | | | 23D. ADDRESS
4808 Harford Rd. Balto 14 Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
5/1/67. | | 24C. NAME OF CEMETERY or CREMATORY
Moreland Memorial Cem. | |
| | | | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
APR 28 1967 | | 25B. NAME OF REGISTRAR
R. D. E. Farber | | 25C. FUNERAL DIRECTOR
Leonard J. Ruck, Inc. Balto. Md. 21214 | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

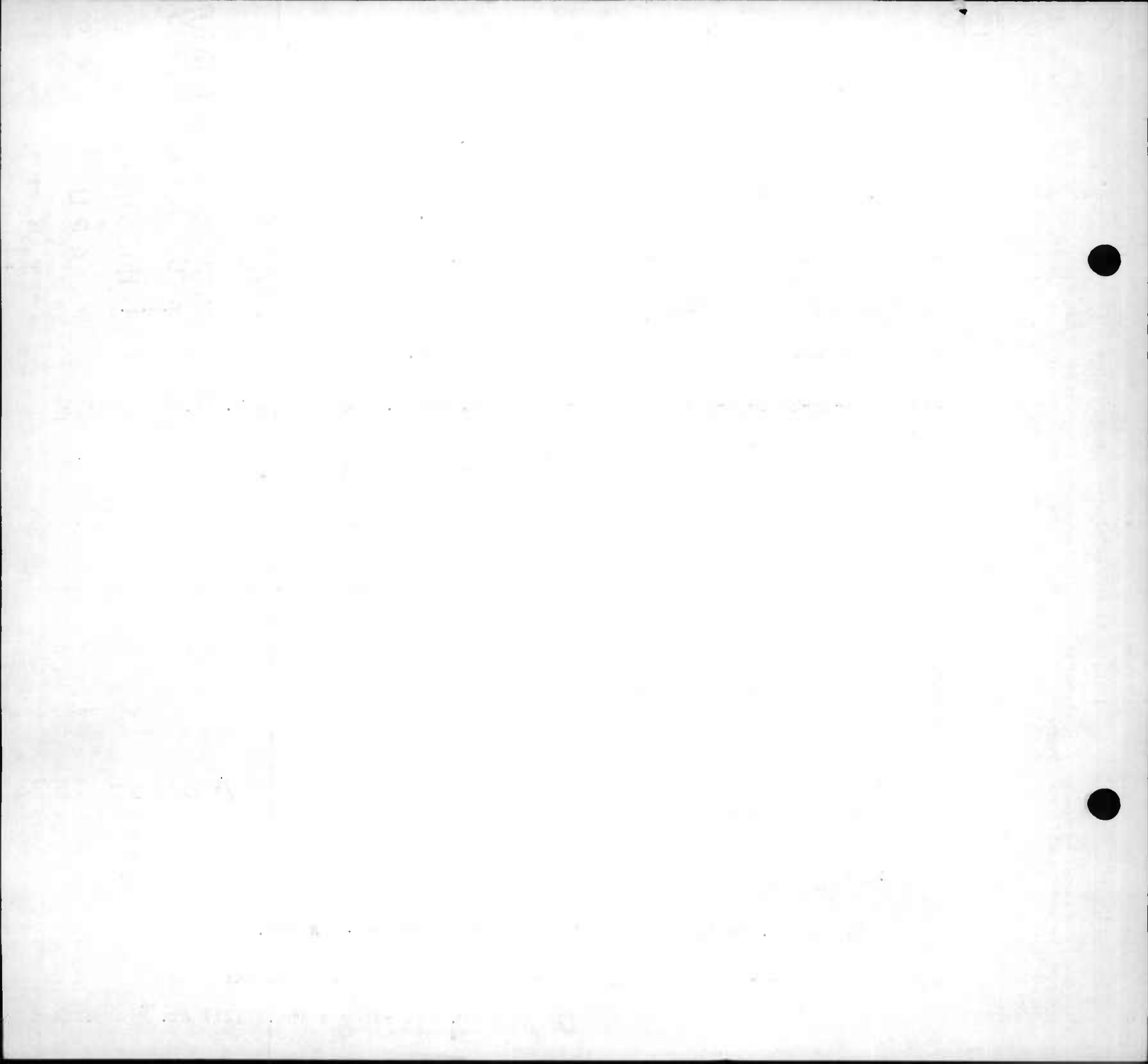
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | | | | | | | | | |
|---|--|---------------------|--|--|--|---|--|--|--|---|--|------------------------------|--|--|---|--|--|--|--|
| G-400 67 4187 | | | | | CERTIFICATE OF DEATH | | | | | Registered No. 67 4187 | | | | | | | | | |
| BIRTH NO. 67 4187 | | | | | | | | | | M.E. CASE NO. | | | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) <i>Oliver Gill</i> | | | | | | | | | | 2. DATE AND HOUR OF DEATH
<i>4/23/67 9⁰⁵ P.M.</i> | | | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND
<i>Bolton Hill Nursing & Convalescent Home</i> | | | | | | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <i>Maryland</i> B. COUNTY | | | | | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<i>90</i> | | | | | | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<i>Baltimore 4-02</i> | | | | | | | | | |
| D. STREET ADDRESS (If rural, give location)
<i>514 Fairmount Ave.</i> | | | | | | | | | | | | | | | | | | | |
| 5. SEX
<i>M</i> | | 6. RACE
<i>W</i> | | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<i>W</i> | | 8. DATE OF BIRTH
<i>NOV. 7, 1870</i> | | 9. AGE (In years last birthday)
<i>96</i> | | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Hours: Min. | | | | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>MILLWRIGHT - RET.</i> | | | | | 10B. KIND OF BUSINESS OR INDUSTRY
<i>WOOD MILL</i> | | | | | 11. BIRTHPLACE (State or foreign country)
<i>MARYLAND</i> | | | | | 12. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | | | |
| 13. FATHER'S NAME
<i>UNKNOWN</i> | | | | | | | | | | 14. MOTHER'S MAIDEN NAME
<i>UNKNOWN</i> | | | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>No</i> | | | | | 16. SOCIAL SECURITY NO.
<i>219-03-1149</i> | | | | | 17. INFORMANT
<i>Robert Smith</i> | | | | | ADDRESS
<i>8313 Charlotte Ct. Annandale, Va.</i> | | | | |
| 18. <i>204.0 I</i>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
<i>CHRONIC LYMPHOCYTIC LEUKEMIA</i> | | | | | | | | | | CAUSE OF DEATH
(A) DUE TO
(B) DUE TO
(C) DUE TO | | | | | | | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | | | | | | | | | |
| 19A. DATE OF OPERATION
<i>0</i> | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20A. AUTOPSY? (Yes or No) | | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | 21F. HOW DID INJURY OCCUR? | | | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>3/31/67</i> 19 to <i>4/23/67</i> 19, that (I) (we) last saw the deceased alive on <i>4/23/67</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | |
| 23A. SIGNATURE
<i>Annis Deanalide</i> M.D. | | | | | | | | | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | | | 23B. DATE SIGNED
<i>4/23/67</i> | | | | |
| 23C. PHYSICIAN'S NAME (Type)
<i>Annis Deanalide</i> | | | | | | | | | | 23D. ADDRESS
<i>5519 Kennison Avenue</i> | | | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>BURIAL</i> | | | | | 24B. DATE
<i>APR. 26, 1967</i> | | | | | 24C. NAME OF CEMETERY OR CREMATORY
<i>Black Rock Cemetery</i> | | | | | 24D. LOCATION (City, town, or county) (State)
<i>Butler, Balto. Co., Md.</i> | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<i>APR 28 1967</i> | | | | | 25B. NAME OF REGISTRAR
<i>R. E. Johnson</i> | | | | | 25C. FUNERAL DIRECTOR
<i>John S. Long</i> | | | | | ADDRESS
<i>Towson, Md.</i> | | | | |

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 4188 | |
|---|---|---|--|---|---|
| BIRTH NO. 67 4188 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) J. ALLEN WOOD | | 2. DATE AND HOUR OF DEATH
April 27, 1967 M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION

829 N. Howard Street | | A. STATE Maryland
B. COUNTY Baltimore | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | | | |
| | | D. STREET ADDRESS (If rural, give location)
829 N. Howard Street | | | |
| 5. SEX
Male | 6. RACE
White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
Married | 8. DATE OF BIRTH
Sept. 5, 1905 | 9. AGE (In years last birthday)
61 | If Under 1 Yr. Months: Days: II Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Tool Engineer | | 10B. KIND OF BUSINESS OR INDUSTRY
Martin Company | | 11. BIRTHPLACE (State or foreign country)
Baltimore | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
John Allen Wood | | | |
| 14. MOTHER'S MAIDEN NAME
Mary E. Buseck | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
Yes 4-22-21 to 4-22-25 | | | |
| 16. SOCIAL SECURITY NO.
218-09-0616 | | 17. INFORMANT ADDRESS
Mrs. Eva D. Wodd 2024 E. Lanvale Street | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) Acute myocardial infarction 1 day
DUE TO
(B) Arteriosclerosis cardio vascular disease
DUE TO
(C) Several years | | INTERVAL BETWEEN ONSET AND DEATH | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from June 1966 to April 27 1967 , that (I) (we) last saw the deceased alive on April 24 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Seymour H. Rubin M.D. | | 23B. DATE SIGNED
4/28/67 | | 23C. PHYSICIAN'S NAME (Type)
Seymour H. Rubin M.D. | |
| 23D. ADDRESS
5415 Park Heights Ave. | | 24. BURIAL CREMATION, REMOVAL (Specify)
Burial | | | |
| 24A. DATE REC'D BY HEALTH DEPT.
5-1-67 | | 24B. NAME OF CEMETERY or CREMATORY
Baltimore Cemetery | | 24C. LOCATION (City, town, or county) (State)
Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR
Wm. Cook-Brooks Inc. | | 25C. FUNERAL DIRECTOR ADDRESS
1217 St. Paul Street | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|-------------------------|--|--|--|--|
| BIRTH NO. 67 4189 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 4189 | |
| CERTIFICATE OF DEATH | | | | | |
| 1. NAME OF DECEASED
(Type or Print) <i>Schofield, William Hull</i> | | 2. DATE AND HOUR OF DEATH
<i>April 26, 1967 11:20 AM</i> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<i>Union Memorial Hospital</i> | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <i>Maryland</i> B. COUNTY <i>Carroll</i>
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<i>Greenmount 56-00</i>
D. STREET ADDRESS (If rural, give location)
<i>Route 1, Box 2, Greenmount</i> | | | |
| 5. SEX
<i>Male</i> | 6. RACE
<i>white</i> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<i>married</i> | 8. DATE OF BIRTH
<i>02-23-00</i> | 9. AGE (In years last birthday)
<i>67</i> | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Stationary Engineer</i> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Stationary Engineer</i> | | 10B. KIND OF BUSINESS OR INDUSTRY
<i>Dept. Store</i> | 11. BIRTHPLACE (State or foreign country)
<i>Maryland</i> | | 12. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> |
| 13. FATHER'S NAME
<i>T. Llan. schafeld</i> | | | 14. MOTHER'S MAIDEN NAME
<i>EMMA SHEHAN</i> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>No</i> | | 16. SOCIAL SECURITY NO.
<i>213-26-0908</i> | 17. INFORMANT
<i>Mrs EDNA E. Schofield</i> | | ADDRESS
<i>Same as # Four</i> |
| 18. <i>154X I</i>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH
(A) <i>Terminal ca.</i>
(B) <i>Recurrent adenocarcinoma</i>
(C) <i>of rectum</i>

INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
<i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<i>No</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>April 11, 1967</i> to <i>April 26, 1967</i> , that (I) (we) last saw the deceased alive on <i>April 26, 1967</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<i>Chi-Tsung Su</i> | | | | 23B. DATE SIGNED
<i>April 26, 67</i> | |
| 23C. PHYSICIAN'S NAME (Type)
<i>CHI-TSUNG SU</i> | | 23D. ADDRESS
M.D. <i>THE UNION MEMORIAL HOSPITAL</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 24B. DATE
<i>4-29-1967</i> | | 24C. NAME OF CEMETERY or CREMATORY
<i>Dulaney Valley Cemetery</i> | |
| 24D. LOCATION (City, town, or county) (State)
<i>Cockeysville, Maryland</i> | | 25A. DATE REC'D BY HEALTH DEPT.
<i>APR 28 1967</i> | | | |
| 25B. NAME OF REGISTRAR
<i>Wm. Cook-Brooks</i> | | 25C. FUNERAL DIRECTOR
<i>Wm. Cook-Brooks</i> | | ADDRESS
<i>Towson 4, Maryland</i> | |

11/20

Apr 8 1962

Schofield William Hall

Mountain
Post Office
Route 1 Box 2 Green Mountain

02-23-62

Mountain

EMMA STEWART

Mrs EDNA E. Schofield

Union Memorial Hospital

Male State Prison

T. Allen Schofield

Term. and Co.
Remount
of return

No

of

April 1962

April 1962

Chick

THE NEWSPAPER

CHICK

1
C-600

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 67 4190 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 4190

M.E. CASE NO.

| | | | | | | | |
|--|------------------|--|---|--|---|---|--|
| 1. NAME OF DECEASED
(Type or Print)
EDWARD A. CURRY | | | | 2. DATE AND HOUR PRONOUNCED DEAD
April 26, 1967 3:00 P M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION
48 Maryland General Hospital | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE Maryland
B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
12-05 Baltimore
D. STREET ADDRESS (If rural, give location)
330 E. Federal Street | | | |
| 5. SEX
Male | 6. RACE
Negro | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married | 8. DATE OF BIRTH
Dec. 25, 1915 | 9. AGE (In years
last birthday)
51 | If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)
Retired | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Baltimore, Md. | | 12. CITIZEN OF
WHAT COUNTRY? | |
| 13. FATHER'S NAME
Unknown | | | 14. MOTHER'S MAIDEN NAME
Unknown | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL
SECURITY NO.
219-07-1846 | | 17. INFORMANT
Lydia Curry
ADDRESS
Same | | |
| 18. 420.0 I
CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, osteoarthritis, etc. It means the disease,
injury or complication which caused death.)
Arteriosclerotic Heart Disease.
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT. | | | | | | INTERVAL BETWEEN
ONSET AND DEATH | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | | 20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH? | |
| 21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.) | | 21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR? | | | |
| 21D. TIME
OF INJURY
(APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE
AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion
resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>
CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ACTUAL SIGNATURE Charles S. Petty M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
EXAMINER'S NAME (Type) Charles S. Petty ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>
DATE SIGNED 4/27/67 | | | | | | | |
| 23A. BURIAL CREMATION,
REMOVAL (Specify)
Burial | | 23B. DATE
4/30/67 | | 23C. NAME OF CEMETERY or CREMATORY
Union Chapel | | 23D. LOCATION (City, town, or county) (State)
Monkton Md. | |
| 24A. DATE REC'D BY HEALTH DEPT.
APR 28 1967 | | 24B. NAME OF REGISTRAR
D. E. E. E. E. | | 24C. FUNERAL DIRECTOR
Arlington S. Phillips
ADDRESS
1727 N. Monroe ST. | | | |

19670004190

RECEIVED
MAY 10 1964
FEDERAL BUREAU OF INVESTIGATION
U.S. DEPARTMENT OF JUSTICE
WASHINGTON, D.C. 20535

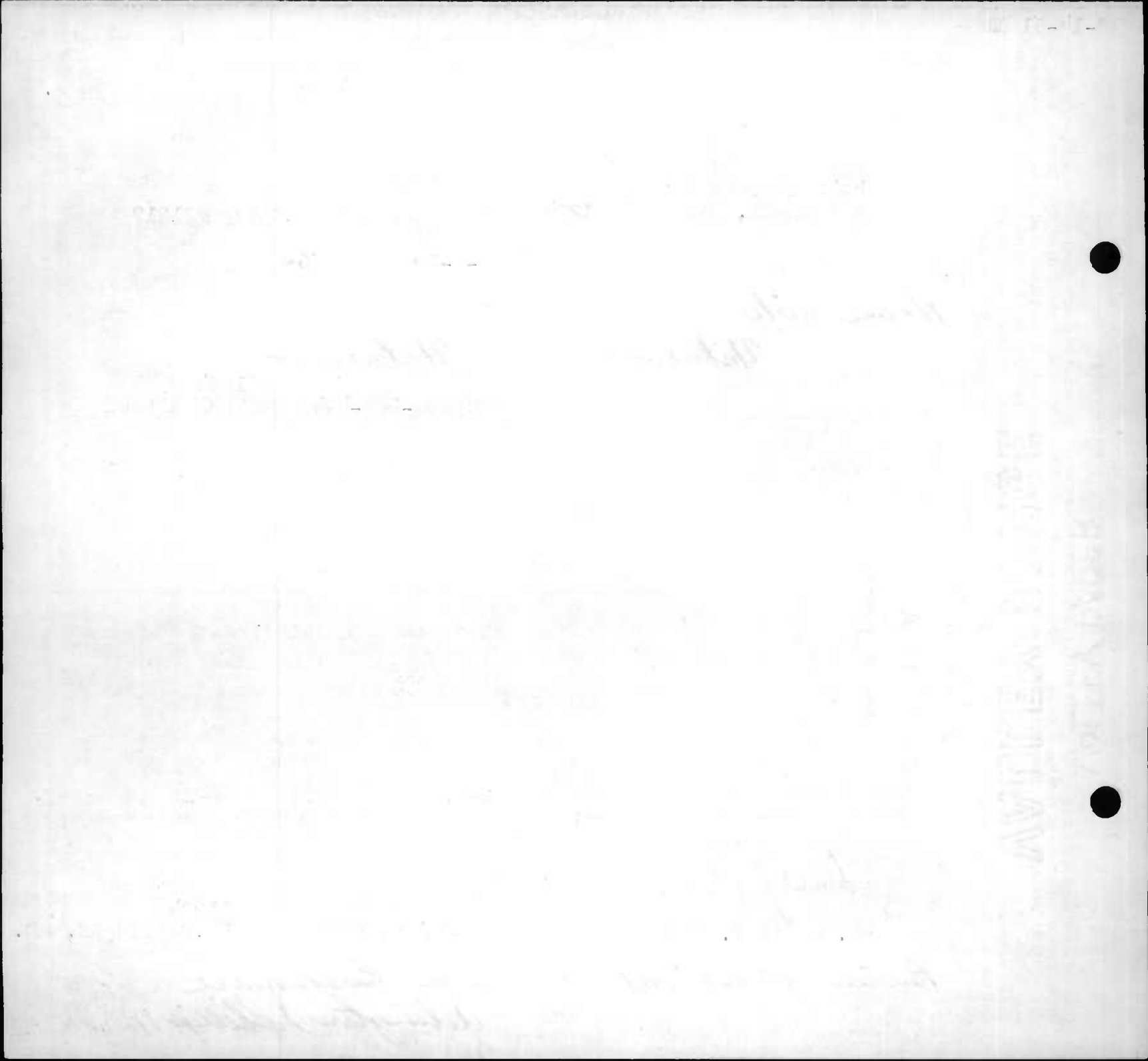
MAILED

30-14-51 1B

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|-------------------------|---|-----------------------------------|--|--|
| BIRTH NO. 67 4191 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 4191 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) Wilhelmina Lambert | | 2. DATE AND HOUR OF DEATH
4-20-67 1:26 A. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
31 BALTIMORE CITY HOSPITALS
4940 EASTERN AVENUE
BALTIMORE, MARYLAND 21224 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE
D. STREET ADDRESS (If rural, give location)
1700 MADISON STREET #21217 | | | |
| 5. SEX
FEMALE | 6. RACE
NEGRO | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
MARRIED | 8. DATE OF BIRTH
8-6-10 | 9. AGE (In years last birthday)
56 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
House wife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
NEW JERSEY | |
| 13. FATHER'S NAME
Unknown | | 14. MOTHER'S MAIDEN NAME
Unknown | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
#21224
RECORDS-BCH-4940 EASTERN AVENUE | |
| 18. 493X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Pneumonia | | CAUSE OF DEATH
(A) DUE TO
(B) DUE TO
(C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH
2 weeks | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
HASCVD with marked renal disease years | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from 1-31 19 67 to 4-20 19 67 , that (1) (we) last saw the deceased alive on 4-19 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
David J. Mishelevich | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
4-20-67 | |
| 23C. PHYSICIAN'S NAME (Type)
DR. DAVID J. MISHELEVICH | | 23D. ADDRESS
21224 BCH-4940 EASTERN AVENUE, BALTIMORE, MD. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burned | | 24B. DATE
4/29/67 | | 24C. NAME OF CEMETERY OR CREMATORY
Mt. Auburn | |
| 24D. LOCATION (City, town, or county) (State)
Baltimore MD. | | 25A. DATE RECEIVED BY HEALTH DEPT.
APR 20 1967 | | 25B. NAME OF REGISTRAR
Robert E. Salzman | |
| 25C. FUNERAL DIRECTOR
Washington Phillips | | ADDRESS
1721 N. Mount | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made. **NANNIE**

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 4192 | |
|---|----------------------|---|----------------------------------|--|--|
| BIRTH NO. 67 4192 | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED
(Type or Print) Nannie Williams (NANNIE WILLIAMS) | | 2. DATE AND HOUR OF DEATH
4/27/67 2:45 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION 33 The Johns Hopkins Hospital
(If not in hospital or institution, give street address or location) | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Baltimore
C. CITY OR TOWN (If outside city limits, write RURAL and give township) 20-01
D. STREET ADDRESS (If rural, give location) 217 North Monroe Street | | | |
| 5. SEX Female | 6. RACE Negro | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH 10/23/97 | 9. AGE (in years last birthday) 69 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY Home | | 11. BIRTHPLACE (State or foreign country) Winnsboro, S.C. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Robert Foster | | | |
| 14. MOTHER'S MAIDEN NAME Laura Evry | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Mrs. Martha Starks 217 N. Monroe St. | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)
420.1 - I
Cardiac arrest | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) myocardial infarction
(C) ASCVD | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Thrombotic arteriosclerosis | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No | | 21. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21C. HOW DID INJURY OCCUR? | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 4/13 19 67 to 4/27 19 67 , that (I) (we) last saw the deceased alive on 4/27 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Kenneth L. Brigham M.D. | | | | 23B. DATE SIGNED 4/27/67 | |
| 23C. PHYSICIAN'S NAME (Type) Kenneth L. Brigham | | 23D. ADDRESS Johns Hopkins Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 4/28/67 | | 24C. NAME OF CEMETERY OR CREMATORY Carmichael Cent. Baltimore Md. | |
| 24D. LOCATION (City, town, or county) Baltimore | | (State) Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. 4/27/67 | | 25B. NAME OF REGISTRAR John E. Johnson | | 25C. FUNERAL DIRECTOR ADDRESS Morton & Dyett, 1701 - Lawrence St. | |

RECEIVED
JAN 11 1967

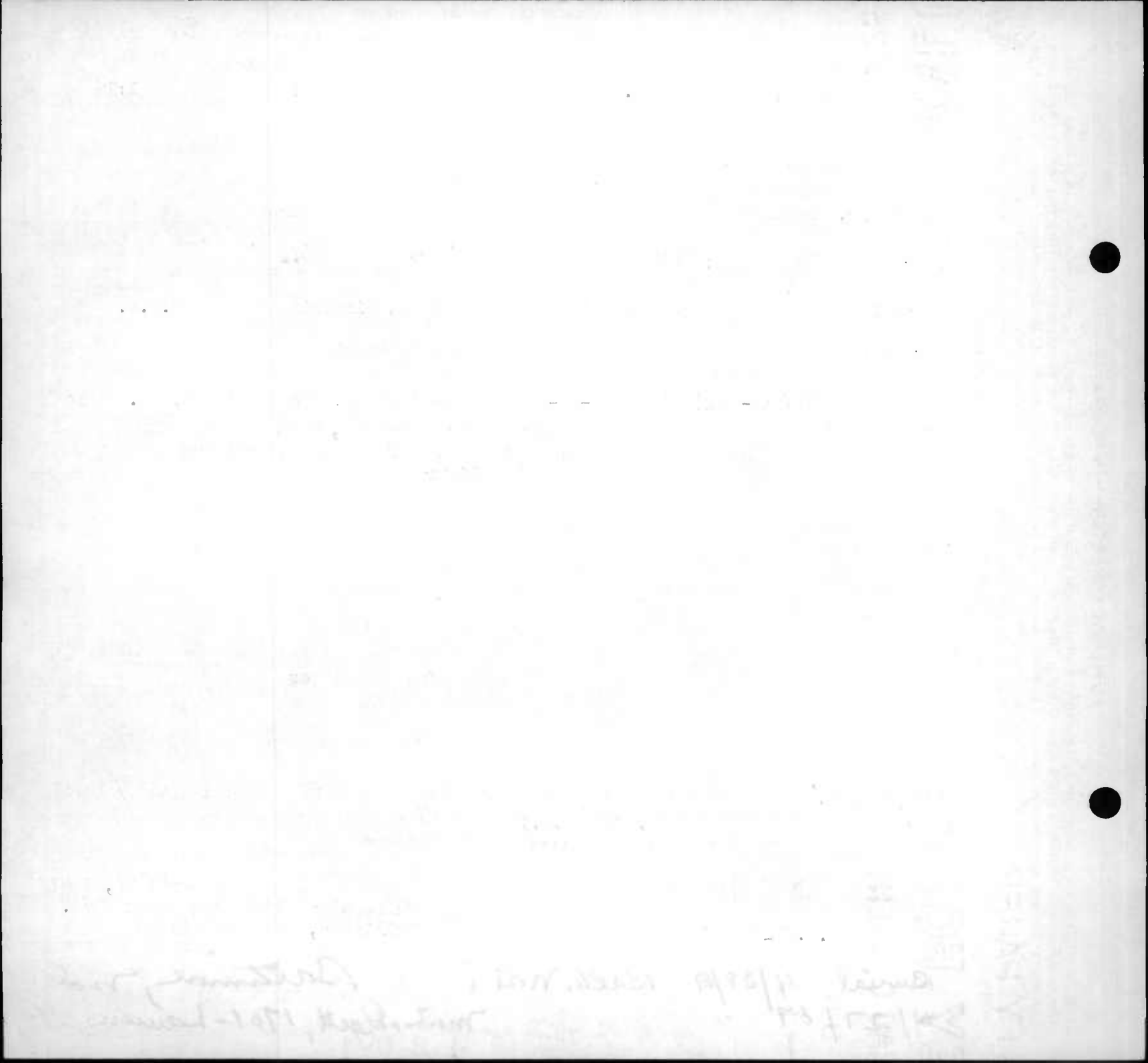
4/27/67

James Earl Ray
Dept. of Justice

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 4193 | |
|---|-------------------------|---|-----------------------------------|--|---|
| BIRTH NO. 67 4193 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) BROWN, Vanderbilt J. | | | |
| 2. DATE AND HOUR OF DEATH
4/27/67 1:25 A M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Baltimore
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
1309 E Federal Street | | | |
| 5. SEX
Male | 6. RACE
Negro | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married | 8. DATE OF BIRTH
6/4/99 | 9. AGE (In years lost birthday)
67 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Laborer | | 10B. KIND OF BUSINESS OR INDUSTRY
Construction | | 11. BIRTHPLACE (State or foreign country)
Sussex, Virginia | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
Edward Brown | | | |
| 14. MOTHER'S MAIDEN NAME
Nannie Harris | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service
Yes 11/17/42 - 10/27/49 | | | |
| 16. SOCIAL SECURITY NO.
218-03-4206 | | 17. INFORMANT ADDRESS
VA Hospital Records Baltimore, Md. 21218 | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
162.1 I Bronchogenic Carcinoma, right upper lobe with metastasis to ribs, vertebrae and liver | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO
(C) | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from March 9th 19 67 to April 27th 19 67 , that (I) (we) last saw the deceased alive on April 27th 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
N Bayadi | | | | 23B. DATE SIGNED
April 27, 1967 | |
| 23C. PHYSICIAN'S NAME (Type)
N.R. El-Bayadi | | 23D. ADDRESS
VA Hospital 3900 Loch Raven Blvd. Baltimore, Maryland 21218 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
4/28/67 | | 24C. NAME OF CEMETERY OR CREMATORY
Baltimore Nat'l | |
| 24D. LOCATION (City, town, or county) (State)
Baltimore, Md | | 25A. DATE REC'D BY HEALTH DEPT.
4/28/67 | | | |
| 25B. NAME OF REGISTRAR
Phyllis E. Fairbanks | | 25C. FUNERAL DIRECTOR ADDRESS
Mother & Galt, 1701 - Laurens St | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. | |
|--|---------|--|------------------|--|---|
| 67 4194 | | CERTIFICATE OF DEATH | | 67 4194 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) | | | |
| | | LEON MILLS | | | |
| 2. DATE AND HOUR OF DEATH | | 4/26 1967 8 ³⁰ P M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location) | | A. STATE B. COUNTY | | | |
| BALTIMORE CITY HOSPITALS
4940 Eastern Avenue
Baltimore, Maryland 21224 | | MARYLAND BALTIMORE Co. | | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | Baltimore 53-00 | | | |
| D. STREET ADDRESS (If rural, give location) | | 669 N AVONDALE ROAD - 21222 | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years
last birthday) | 10. Under 1 Yr.
Months Days Hours Min. |
| MALE | NEGRO | SEPARATED | 7/13/30 | 36 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Laborer | | A.A. Chemical Co. | | Halifax Co., N.C. | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| William T. Mills Sr. | | Lizzie Ella Johnson | | U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMATION ADDRESS | |
| | | 246-10-7695 | | RECORDS: BCH, 4940 Eastern Ave., Balto. Md. 21224 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| 753.11 | | CELEBRAL HEMORRHAGE 6 days | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) DUE TO | | | |
| | | (B) DUE TO | | | |
| | | (C) DUE TO | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 4/20/67 | | AQUELECTAL STENOSIS | | NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | |
| 22. I certify that (1) (this hospital) attended the deceased from 4/20 19 67 to 4/26 19 67. that (2) (we) last saw the deceased alive on 4/26 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (3) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| Stuart Beal Silver M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 4/26/67 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| STUART BEAL SILVER | | | | 4940 Eastern Avenue, Balto., Md. 21224 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 4/28/67 | | Halifax, Weldon N.C. Weldon N.C. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| 4/27/67 | | Robert E. Taylor | | Morton Payett, funeral home, 1701-Lanier St | |

9 3 3 0

7 04 00

38

37

CLIFFORD B. BROWN

4/30/63 BIRTHDAY

4/22/63

33

4/24

4/20

CLIFFORD B. BROWN

CLIFFORD B. BROWN

CLIFFORD B. BROWN

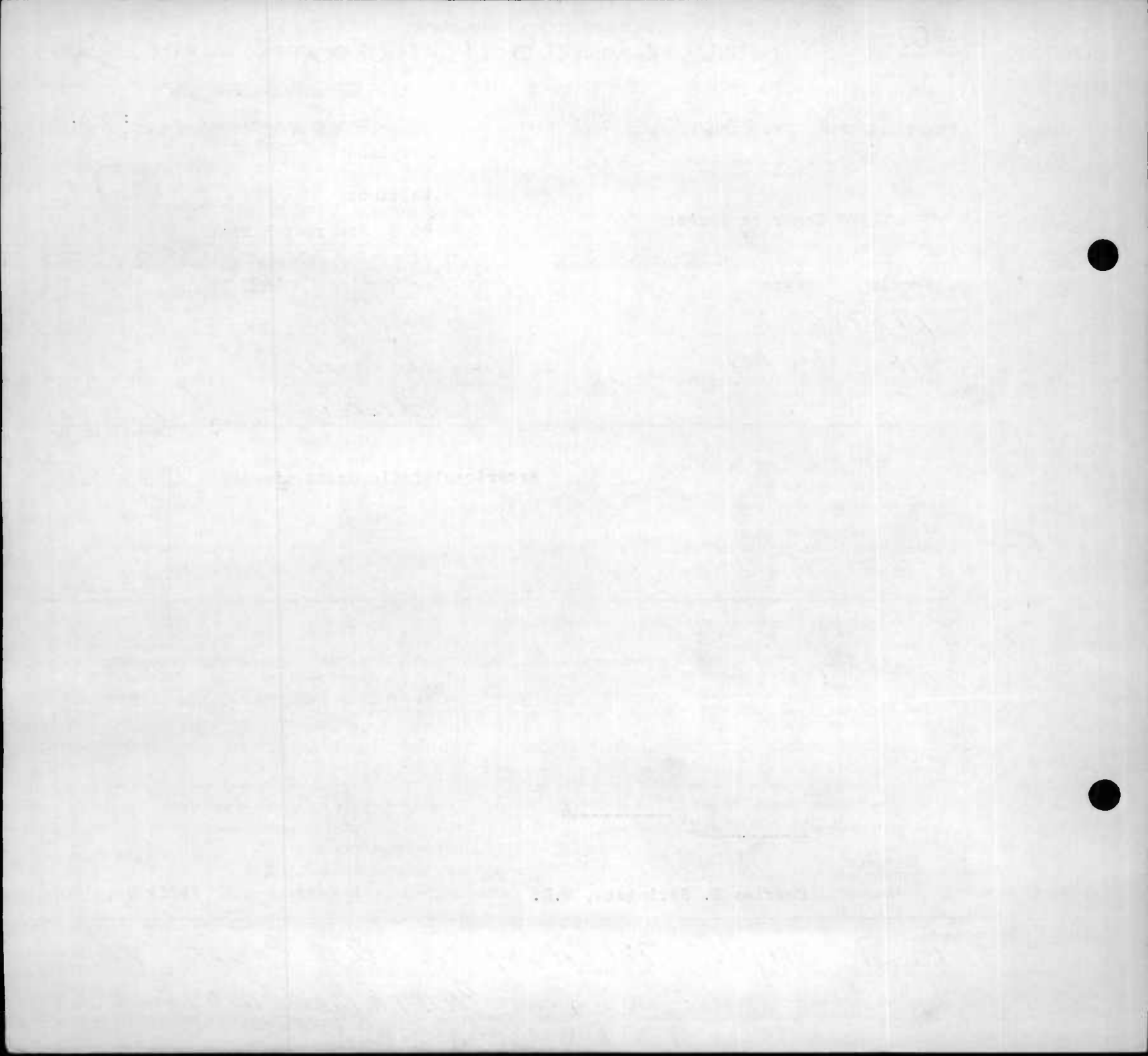
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | | | | |
|--|--|---------------------------|--|--|--|--|--|--|--|---|--|-----------------------------|--|--|
| BIRTH NO. 67 4195 | | | | | CERTIFICATE OF DEATH | | | | | Registered No. 67 4195 | | | | |
| 1. NAME OF DECEASED
(Type or Print) FLORENCE LOGAN | | | | | 2. DATE AND HOUR OF DEATH
APRIL 27-1967 1 40A M. | | | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD
B. COUNTY | | | | | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
00
2408 HARLEM AVE | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE
16-05 | | | | | | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location)
2408 HARLEM AVE | | | | | | | | | |
| 5. SEX
FE | | 6. RACE
COLORED | | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)
MARRIED | | 8. DATE OF BIRTH
DEC-2-1900 66 | | 9. AGE (In years last birthday)
66 | | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
RET. LABORER | | | | | 10B. KIND OF BUSINESS OR INDUSTRY
BALTO TRANSIT CO | | | | | 11. BIRTHPLACE (State or foreign country)
SUFFOLK VA | | | | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | 13. FATHER'S NAME
WELDON WHITAKER | | | | | 14. MOTHER'S MAIDEN NAME
NORA BROWN | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | | | | 16. SOCIAL SECURITY NO. | | | | | 17. INFORMANT
CLEMENTINE JONES ADDRESS 10 RAET 188TH AVE NEW YORK N.Y. 2C | | | | |
| 18. 157X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
CAUSE OF DEATH
CARCINOMA OF PANCREAS
(A) DUE TO
6 MONTHS (?)
INTERVAL BETWEEN ONSET AND DEATH
6 MONTHS (?) | | | | | 19. DATE OF OPERATION
0 | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | |
| 20A. AUTOPSY? (Yes or No) | | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 4/13 19 67 to 4/27 19 67 , that (I) (we) last saw the deceased alive on 4/24/67 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | 23A. SIGNATURE
J. Presto n Grant M.D.
23C. PHYSICIAN'S NAME (Type)
J. Presto n Grant, M.D. | | | | |
| 23B. DATE SIGNED
4/28/67 | | | | | 23D. ADDRESS
601 N. CARROLLTON | | | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | | | | 24B. DATE
4/30/67 | | | | | 24C. NAME OF CEMETERY or CREMATORY
ARBUTUS MEM. PK | | | | |
| 24D. LOCATION (City, town, or county) (State)
BALTO MD 21228 | | | | | 25A. DATE REC'D BY HEALTH DEPT.
MAY 1 1967 | | | | | 25B. NAME OF REGISTRAR
Robert E. Fairley | | | | |
| 25C. FUNERAL DIRECTOR
Manhattan Pflaum | | | | | 25D. ADDRESS
638 N. GUMMA ST | | | | | | | | | |

My dear Mr. [illegible]
I have the honor to acknowledge
the receipt of your letter of the
10th inst. and in reply to inform
you that the same has been
forwarded to the proper
authorities for their consideration.
I am, Sir, very respectfully,
Your obedient servant,
[illegible]

[Faint, illegible text, likely bleed-through from the reverse side of the page.]



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G-450

| BALTIMORE CITY HEALTH DEPARTMENT | | | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 4197 | | | |
|---|------------------|---|------------------------------|---|---|--|--|
| BIRTH NO. 67 4197 | | | | M.E. CASE NO. | | | |
| 1. NAME OF DECEASED
(Type or Print) EUGENE <i>Lurge</i> GLENN | | | | 2. DATE AND HOUR PRONOUNCED DEAD
April 26, 1967 11:15 P M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
00 1628 Harford Avenue | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE Maryland B. COUNTY <i>Bolton Co.</i>
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 53-00
D. STREET ADDRESS (If rural, give location) 5904 Leewood Avenue | | | |
| 5. SEX
Male | 6. RACE
Negro | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)
MARRIED | 8. DATE OF BIRTH
4/5/1911 | 9. AGE (In years last birthday)
55 56 | If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
CRANE OPERATOR | | 10B. KIND OF BUSINESS OR INDUSTRY
STEEL | | 11. BIRTHPLACE (State or foreign country)
LAURENS, S.C. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME
ROBT. GLENN | | | | 14. MOTHER'S MAIDEN NAME
LORELLA BEASLEY | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)
YES WW #2 | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
ANGIE MIRIAM GLENN 5904 LEEWOOD AVE. | | | |
| 18. 420.01
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
CAUSE OF DEATH
(A) Arteriosclerotic Heart Disease.
DUE TO
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) DUE TO
(C) OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>
ACTUAL SIGNATURE <i>Charles S. Petty</i> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>
EXAMINER'S NAME (Type) Charles S. Petty ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 4/27/67 | | | | | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 23B. DATE
5/2/67 | | 23C. NAME OF CEMETERY or CREMATORY
BALTIMORE NATL | | 23D. LOCATION (City, town, or county) (State)
5501 FREDK AVE. | |
| 24A. DATE REC'D BY HEALTH DEPT.
MAY 1 1967 | | 24B. NAME OF REGISTRAR
Robert E. Farley | | 24C. FUNERAL DIRECTOR
Milton E. Elickson | | | |

4/27/11
 230
 C.2
 J.2
 J.2
 J.2

Married
 C.2
 J.2
 J.2
 J.2

Buyl 2/2/11 Baltimore Md 2201 Jack Ave
 J.2
 J.2
 J.2

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

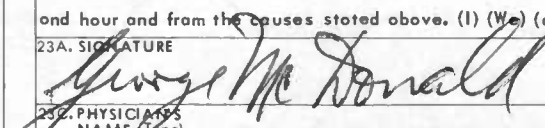
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 4198 | |
|--|---------------------------|---|-------------------------------------|--|---|
| BIRTH NO. 67 4198 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) LORRAINE HARRIS | | 2. DATE AND HOUR OF DEATH
APRIL 26, 1967 8:45 P. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

758 E. RICHWOOD AVENUE | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY

C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE
D. STREET ADDRESS (If rural, give location)
758 E. RICHWOOD AVE. | | | |
| 5. SEX
FEMALE | 6. RACE
COLORED | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
WIDOWED | 8. DATE OF BIRTH
4-6-1886 | 9. AGE (In years last birthday)
81 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
BOLTON, MISSISSIPPI | |
| 13. FATHER'S NAME
WILLIAM H. JOHNSON | | 14. MOTHER'S MAIDEN NAME
MARY C. JOHNSON | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
425-62-0974 J | | 17. INFORMANT ADDRESS
RUBY GILL - 758 E. RICHWOOD AVE. | |
| 18. 420.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
Coronary Occlusion
(A) DUE TO

Conjastive heart failure
(B) DUE TO

A.H.C.V.D.
(C) | | INTERVAL BETWEEN ONSET AND DEATH
? | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
None | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 3/31/61 19 to Apr. 26, 1967 19, that (I) (we) last saw the deceased alive on Apr. 25, 1967 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
 | | | | 23B. DATE SIGNED
4/28/67 | |
| 23C. PHYSICIAN'S NAME (Type)
GEORGE McDONALD | | 23D. ADDRESS
M.D. 844 N. CAREY STREET, BALTIMORE, MD. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
5-1-67 | | 24C. NAME OF CEMETERY or CREMATORY
MT. AUBURN | |
| 24D. LOCATION (City, town, or county) (State)
BALTIMORE, MARYLAND | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS
CHARLES R. LAW 802 MADISON AVE. | |

OFFICE OF THE
SHERIFF

W. P. R. G. W.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Certificate of Death | | Registered No. 67 4199 | |
|---|---------------|---|--------------------------|---|---|---|--|
| BIRTH NO. 67 4199 | | M.E. CASE NO. | | DATE AND HOUR OF DEATH April 28 1967 12:55 AM | | | |
| 1. NAME OF DECEASED (Type or Print) Charles W. Johnson | | 2. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | D. STREET ADDRESS (If rural, give location) 1811 N. WASHINGTON STREET 21213 | | | |
| 5. SEX MALE | 6. RACE NEGRO | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 6-20-00 | 9. AGE (In years, lost birthday) 66 | 10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Insurance Agent | | 10B. KIND OF BUSINESS OR INDUSTRY Insurance Co. | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Reginald Johnson | | 14. MOTHER'S MAIDEN NAME Clara Gilbert | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Ethel A. Johnson - 1811 N. Washington St. | | ADDRESS | | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) DUE TO H.C.V.P. = Right middle cerebral artery occlusion (B) DUE TO Cardiac arrhythmia (C) | | INTERVAL BETWEEN ONSET AND DEATH 8 days | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 4/19 19 67 to 4/28 19 67, that (I) lost saw the deceased alive on 4/28 19 67 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE David S. Fedson M.D. | | 23B. DATE SIGNED 4-28-67 | | 23C. PHYSICIAN'S NAME (Type) DAVID S. FEDSON | | 23D. ADDRESS THE JOHNS HOPKINS HOSPITAL | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 5-2-67 | | 24C. NAME of CEMETERY or CREMATORY Arbutus Memorial Park | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. MAY 1 1967 | | 25B. NAME OF REGISTRAR Robert E. Fedson | | 25C. FUNERAL DIRECTOR Charles R. Law | | ADDRESS 802 Madison Ave. | |

Charles E. Johnson

April 28 12:22 PM

WCP e Right 8 days
Wright center
center ocean
+ center center

for

4/28

4/27

4/26

4/25

David's father

x

4-25-4

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|------------------|--|-----------------------------------|--|--|
| BIRTH NO. 67 4200 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 4200 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) Sister Mary Henrietta Rannie | | 2. DATE AND HOUR OF DEATH
4/25/67 8:15 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Mercy Hospital | | MARYLAND | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE | | 27-15 | |
| | | D. STREET ADDRESS (If rural, give location)
SMITH AVE MT. ST. AGNES CONVENT | | | |
| 5. SEX
FEMALE | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
SINGLE | 8. DATE OF BIRTH
MAR. 20, 1888 | 9. AGE (In years last birthday)
79 | 10. If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
RELIGIOUS SISTER OF MERCY | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME
WILLIAM RANNIE | | 14. MOTHER'S MAIDEN NAME
KATHERINE GAITHER | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
SR. M. THOMAS RSM MERCY HOSPITAL | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) Possible myocardial infarction
(B) Complete heart block
(C) ASCVD | | INTERVAL BETWEEN ONSET AND DEATH
24 hrs
5 yrs | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)
Yes | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 4/24 to 4/25 19 67 that (I) (we) last saw the deceased alive on 4/25 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Louis E. Denyer | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
4/25/67 | |
| 23C. PHYSICIAN'S NAME (Type)
MERCY HOSPITAL | | 23D. ADDRESS
M.D. BALTIMORE, MD. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
MAY 1, 1967 | | 24C. NAME OF CEMETERY or CREMATORY
MT. ST. AGNES CONVENT CEM. BALTIMORE, MD. | |
| 24D. LOCATION (City, town, or county) (State) | | 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR
H. W. MEARS & SON 805 N. CALVERT ST. | |
| | | 25C. FUNERAL DIRECTOR ADDRESS | | | |

THE
OFFICE OF THE
ATTORNEY GENERAL
STATE OF NEW YORK
ALBANY

STATE OF NEW YORK
IN SENATE
JANUARY 1, 1901

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | X | | Registered No. | |
|--|------------------|---|--|---|---|---|--|
| BIRTH NO. 67 4201 | | REUBIN | | WHITE | | 67 4201 | |
| M.E. CASE NO. | | | | 2. DATE AND HOUR OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) REUBEN WHITE | | | | APRIL 26, 1967 5:40 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location)
SINAI HOSPITAL OF BALTIMORE | | | | A. STATE
D.C.
B. COUNTY
WASHINGTON V-48
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location)
1328 LEWIS ST. N.E. | | | |
| 5. SEX
MALE | 6. RACE
NEGRO | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
SINGLE | 8. DATE OF BIRTH
6/27/25 | 9. AGE (In years last birthday)
41 | 10. Under 1 Yr. Months Days
11. Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
BARBER | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country)
ALABAMA | | 12. CITIZEN OF WHAT COUNTRY?
USA | | |
| 13. FATHER'S NAME
ABRAHAM WHITE | | | 14. MOTHER'S MAIDEN NAME
BESSIE WATKINS | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
YES WORLD WAR II | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS
ABRAHAM WHITE | | | | |
| 18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ACUTE MYOCARDIAL INFARCTION
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last,
HYPERTENSIVE CARDIOVASCULAR DISEASE
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | INTERVAL BETWEEN ONSET AND DEATH
2 HOURS | | | |
| 19A. DATE OF OPERATION
O | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 4/26 1967 to 4/26 1967, that (I) (we) lost saw the deceased alive on 4/26 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
Melvyn B. Lewis | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
4/26/67 | |
| 23C. PHYSICIAN'S NAME (Type)
MELVYN B. LEWIS | | | | 23D. ADDRESS
M.D. SINAI HOSPITAL OF BALTO. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
5-2-1967 | | 24C. NAME OF CEMETERY or CREMATORY
ALEXANDRIA | | 24D. LOCATION (City, town, or county) (State)
ALEXANDRIA, VIRGINIA | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 1 1967 | | 25B. NAME OF REGISTRAR
Robert E. Johnson | | 25C. FUNERAL DIRECTOR ADDRESS
W. ERNEST JARVIS CO. 1432 YOU STREET N.W. | | | |

ABRAHAM WHITE
BARBER
100 WARD WALK

ABRAHAM WHITE
BARBER
100 WARD WALK

ABRAHAM WHITE
BARBER
100 WARD WALK

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. | |
|--|---------|--|---|--|--|
| 67 4202 | | CERTIFICATE OF DEATH | | 67 4202 | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED
(Type or Print) | | | 2. DATE AND HOUR OF DEATH | | |
| MC CAULEY, HENRY FRANKLIN | | | APRIL 27, 1967 10:00 A.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | A. STATE B. COUNTY | | |
| ST. AGNES HOSPITAL | | | MARYLAND HOWARD COUNTY | | |
| | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | |
| | | | ELLICOTT CITY 63-00 | | |
| | | | D. STREET ADDRESS (If rural, give location) | | |
| | | | 120 MAIN ST. | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| MALE | WHITE | MARRIED | 4/30/01 | 65 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? |
| DISABLED | | | ALEXANDRIA, VIRGINIA | | U.S.A. |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| WALTER (DEC'D) | | | SUSAN ALLISON (DEC'D) | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS |
| NONE | | | 215-10-5539 | | ST. AGNES HOSPITAL RECORDS |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | CAUSE OF DEATH | | |
| (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| ANTECEDENT CAUSES | | | (A) MYOCARDIAL INFARCTION - | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (B) CHRONIC CONGESTIVE HEART FAILURE | | |
| | | | (C) GLOMERULOSCLEROSIS AND UREMIA | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 0 | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from APRIL 26 19 67 to APRIL 27 19 67, that (I) (we) last saw the deceased alive on APRIL 27 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| XXXXXX XXXX | | | | 04-27-67 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| JUAN S. CABRERA M.D. | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 4-29-1967 | | Good Shepherd | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| MAY 1 1967 | | R. E. F. J. F. J. | | F. C. Higginbotham, Ellicott City, Md. | |

1000

APRIL 1, 1952

DEPT. OF HEALTH, EDUCATION & WELFARE

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE

APRIL 1, 1952

APRIL 1, 1952

APRIL 1, 1952

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | | | Registered No. <u>67 4203</u> | |
|---|-------------------------|--|---|--|--|
| BIRTH NO. <u>35 67 4203</u> | | M.E. CASE NO. | | 2. DATE AND HOUR OF DEATH
<u>APRIL 25, 1967</u> <u>2:50 P. M.</u> | |
| 1. NAME OF DECEASED
(Type or Print)
<u>IDA GOLDENBERG</u> | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <u>MARYLAND</u>
B. COUNTY <u>BALTIMORE</u> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<u>3626 FORDS LANE, APT 3C</u> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>BALTIMORE</u>
D. STREET ADDRESS (If rural, give location)
<u>3626 FORDS LANE, APT 3C</u> | | | |
| 5. SEX
<u>FEMALE</u> | 6. RACE
<u>WHITE</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
<u>MARRIED</u> | 8. DATE OF BIRTH
<u>JAN. 12, 1889</u> | 9. AGE (In years last birthday)
<u>78</u> | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>HOUSEWIFE</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>AT HOME</u> | 11. BIRTHPLACE (State or foreign country)
<u>NEW YORK CITY</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> |
| 13. FATHER'S NAME
<u>MORITZ FRIEDMAN</u> | | | 14. MOTHER'S MAIDEN NAME
<u>HANNAH ?</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>NO</u> | | 16. SOCIAL SECURITY NO.
<u>UNKNOWN</u> | 17. INFORMANT
<u>MRS. MYRA ROSEMAN, 2419 HUNT DRIVE #9</u> | | |
| 18. <u>420.1 I</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)
<u>Heart disease with Coronary Insufficiency</u>
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
<u>Arteriosclerosis</u> | | CAUSE OF DEATH
(A) <u>Myocardial Infarction</u>
(B) <u>Insufficiency</u>
(C) <u>Arteriosclerosis</u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>30 1/2 years</u>
<u>years</u> | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
<u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Jan 15 1946</u> to <u>April 25 1967</u> , that (I) (we) last saw the deceased alive on <u>April 15 1967</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>Dr. Louiston L. Keown</u> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | | 23B. DATE SIGNED
<u>26 April 67</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>DR. LOUISTON L. KEOWN</u> | | 23D. ADDRESS
<u>431 E. LAKE AVENUE</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | 24B. DATE
<u>4/27/67</u> | | 24C. NAME OF CEMETERY OR CREMATORY
<u>MARYLAND LODGE</u> | |
| 24D. LOCATION
<u>BALTIMORE, MARYLAND</u> | | 25A. DATE REC'D BY HEALTH DEPT.
<u>MAY 1 1967</u> | | | |
| 25B. NAME OF REGISTRAR
<u>Robert E. Taylor</u> | | 25C. FUNERAL DIRECTOR
<u>SOL LEVINSON & BROS. INC., 6010 REIST., RD.</u> | | | |

James M. Thompson
12th Street
New York City

12th Street

James M. Thompson
X

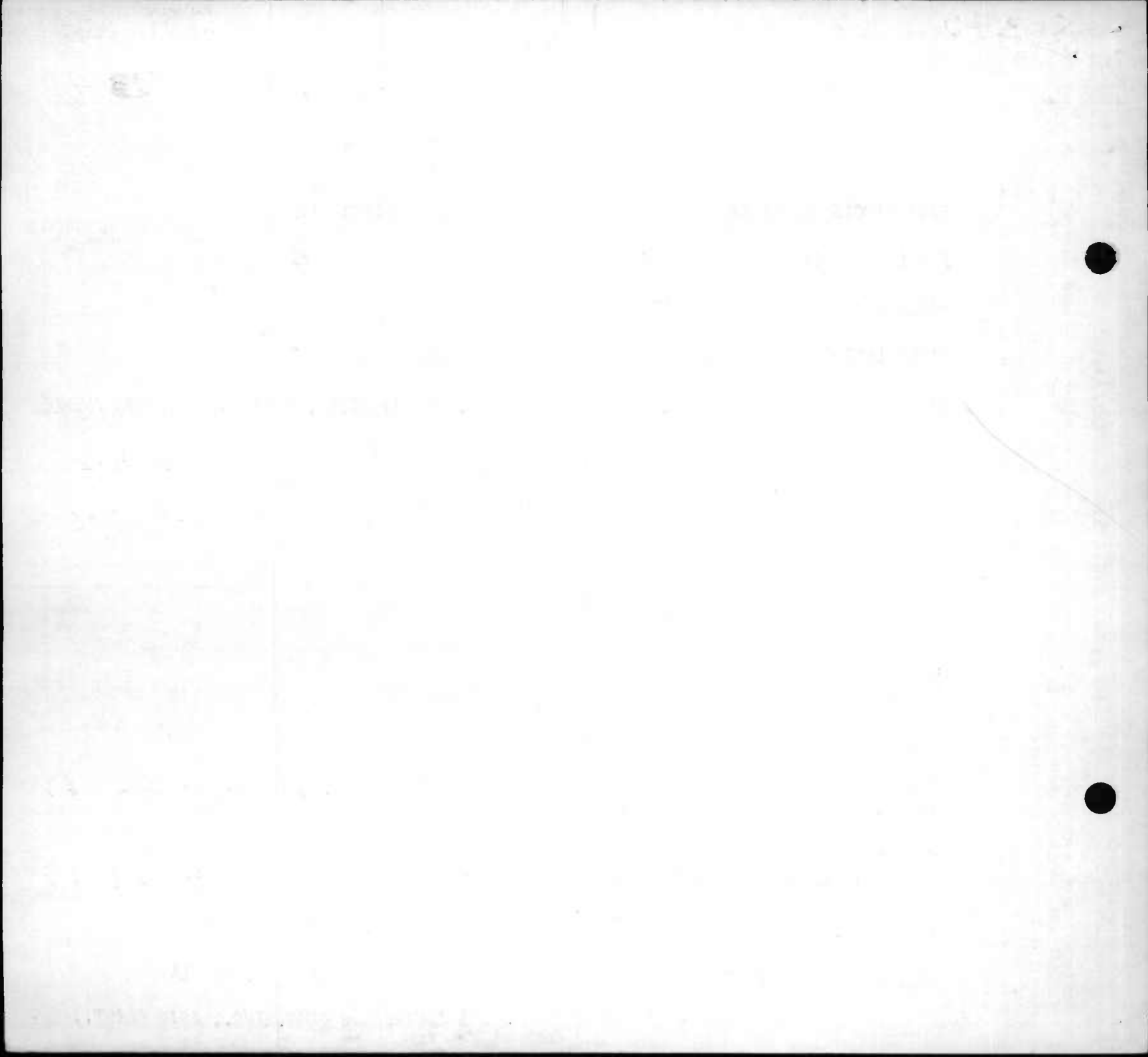
12th Street

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>67 4204</u> | |
|---|-------------------------|--|---|---|--|
| BIRTH NO. <u>67 4204</u> | | | | M.E. CASE NO. | |
| 1. NAME OF DECEASED
(Type or Print) <u>SARAH SIDLE</u> | | | 2. DATE AND HOUR OF DEATH
<u>APRIL 26, 1967</u> <u>1</u> <u>A.</u> M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<u>5706 NARCISSUS AVENUE</u> | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE <u>MARYLAND</u>
B. COUNTY <u>BALTIMORE</u>
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>27-19</u>
D. STREET ADDRESS (If rural, give location) <u>5706 NARCISSUS AVENUE</u> | | |
| 5. SEX
<u>FEMALE</u> | 6. RACE
<u>WHITE</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
<u>WIDOWED</u> | 8. DATE OF BIRTH
<u>82</u> | 9. AGE (In years last birthday)
<u>82</u> | If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>HOUSEWIFE</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>AT HOME</u> | | 11. BIRTHPLACE (State or foreign country)
<u>RUSSIA</u> |
| 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | | 13. FATHER'S NAME
<u>MAYER LEVINSON</u> | | |
| 14. MOTHER'S MAIDEN NAME
<u>HANNAH ?</u> | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service
<u>NO</u> | | |
| 16. SOCIAL SECURITY NO.
<u>UNKNOWN</u> | | | 17. INFORMANT
<u>MR. HERMAN SIDLE, 6603 PARK HEIGHTS AVENUE</u> | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
<u>Coronary Occlusion</u> | | | INTERVAL BETWEEN ONSET AND DEATH
<u>2 hrs</u> | | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
<u>Hypertensive h.v. Dis.</u> | | | (B) DUE TO
<u>10 yrs</u> | | |
| 20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
<u>II</u> | | | (C) DUE TO | | |
| 21A. DATE OF OPERATION | | 21B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Net While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Nov 19 1957</u> to <u>Apr 26 1967</u> , that (I) (we) last saw the deceased alive on <u>Apr 26 1967</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>Dr. Irvin Sauber</u> M.D. | | | | 23B. DATE SIGNED
<u>4-26-67</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>DR. IRVIN SAUBER</u> M.D. | | | | 23D. ADDRESS
<u>6905 PARK HEIGHTS AVENUE</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | 24B. DATE
<u>4/27/67</u> | | 24C. NAME of CEMETERY or CREMATORY
<u>NESTINA</u> | |
| 24D. LOCATION
<u>BALTIMORE, MARYLAND</u> | | 24E. CITY, town, or county (State) | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>MAY 1 1967</u> | | 25B. NAME OF REGISTRAR
<u>Robert E. Feilberg</u> | | 25C. FUNERAL DIRECTOR
<u>SOL LEVINSON & BROS. INC., 6010 REIST., RD.</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | | | | | | | | | Registered No. 67 4205 4 | |
|---|--|-------------------------|--|---|--|---|--|--|--|--|--|
| BIRTH NO. 67-0889167 4205 | | | | | | | | | | | |
| M.E. CASE NO. | | | | | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) BABY GIRL CORREA | | | | | | 2. DATE AND HOUR OF DEATH
4/27/67 3 20/A M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD B. COUNTY Balts Co | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
34 BON SECOURS HOSP. 2025 W. FAYETTE ST. BALTO. MD. 21223 | | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE 53-00 | | | | | |
| D. STREET ADDRESS (If rural, give location)
4217 McDOWELL LANE (21227) | | | | | | | | | | | |
| 5. SEX
FEMALE | | 6. RACE
WHITE | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
NEVER MARRIED | | 8. DATE OF BIRTH
4/27/67 | | 9. AGE (In years last birthday)
— | | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
— — — 57 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Child | | | | | | 10B. KIND OF BUSINESS OR INDUSTRY
None | | | | | |
| 11. BIRTHPLACE (State or foreign country)
MARYLAND | | | | | | 12. CITIZEN OF WHAT COUNTRY?
USA | | | | | |
| 13. FATHER'S NAME
LOUIS A. CORREA | | | | | | 14. MOTHER'S MAIDEN NAME
JACQUELINE BREWER | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | | | | | 16. SOCIAL SECURITY NO.
— | | 17. INFORMANT ADDRESS
Linwood Brewer - 862 Joyce Ave - 21222 | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
726X1 | | | | | | CAUSE OF DEATH
(A) DUE TO Prematurity
(B) DUE TO
(C) | | | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II | | | | | | INTERVAL BETWEEN ONSET AND DEATH
Aspiration | | | | | |
| 19A. DATE OF OPERATION
2 | | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 4/27 1967 to 4/27 1967 , that (I) (we) last saw the deceased alive on 4/27 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE
[Signature] | | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
4/27/67 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | | | 23D. ADDRESS
Bon Secours Hospital 2025 W. Fayette St. Baltimore, Md. | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | | | 24B. DATE
4/28/67 | | 24C. NAME OF CEMETERY or CREMATORY
Landon Park Cem. | | | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 1 1967 | | | | 25B. NAME OF REGISTRAR
[Signature] | | | | 25C. FUNERAL DIRECTOR
[Signature] | | | |

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[Faint, illegible handwriting, possibly bleed-through from the reverse side of the page.]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|--------------|--|------------------------------|--|-------------------------------------|
| BIRTH NO. 67 4206 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 4206 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) JULIUS MANDEL MANDEL | | 2. DATE AND HOUR OF DEATH
4/27/67 12 ³⁰ P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
SINAL HOSPITAL OF BALTIMORE | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE NO. B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE 21205 27-17
D. STREET ADDRESS (If rural, give location)
LEVINDALE NURSING HOME | | | |
| 5. SEX
M | 6. RACE
W | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
WID | 8. DATE OF BIRTH
11/20/93 | 9. AGE (In years last birthday)
73 | 10. CITIZEN OF WHAT COUNTRY?
USA |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
CLERK | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
AUSTRIA | |
| 13. FATHER'S NAME
HERMAN | | 14. MOTHER'S MAIDEN NAME
BETTY | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
215-14615 | | 17. INFORMANT
FRED MANDEL 1781 RIVERSIDE DRIVE | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc., it means the disease, injury or complication which caused death.)
CAUSE OF DEATH
420.1 I
MYOCARDIAL INFARCTION 3DA.- | | (A) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO | | | |
| (C) DUE TO | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
D | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 4/26/67 19 67 to 4/27/67 19 67, that (I) (we) last saw the deceased alive on 4/27/67 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Sheldon Frank | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
4/27/67 | |
| 23C. PHYSICIAN'S NAME (Type)
SHELDON FRANK | | 23D. ADDRESS
SINAL HOSPITAL OF BALTIMORE | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
4/28/67 | | 24C. NAME of CEMETERY or CREMATORY
Cherry Chapel | |
| 24D. LOCATION (City, town, or county) (State)
Randallstown Md | | 25A. DATE REC'D BY HEALTH DEPT.
MAY 1 1967 | | | |
| 25B. NAME OF REGISTRAR
Robert E. Taylor | | 25C. FUNERAL DIRECTOR
Sydney S. Givens | | | |
| 25D. ADDRESS
Givens, Md | | | | | |

67 4207

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 4207

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

VALENTINE

SACZALSKI

2. DATE AND HOUR PRONOUNCED DEAD

April 27, 1967

3:43 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

00 2422 Fleet Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2422 Fleet Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

4-14-1880

9. AGE (In years
last birthday)

86

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Bar Keeper

10B. KIND OF BUSINESS OR INDUSTRY

Tavern

11. BIRTHPLACE (State or foreign country)

Poland

12. CITIZEN OF
WHAT COUNTRY?

U S A

13. FATHER'S NAME

Saczsalski

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

104-07-2754A

17. INFORMANT

ADDRESS

Pauline Saczsalski 2422 Fleet Street

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Heart Disease.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE
AT WORK ☐

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Petty

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4/27/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

5-1-67

23C. NAME OF CEMETERY or CREMATORY

St Stanislaus Cemetery

23D. LOCATION

(City, town, or county)

Baltimore, Maryland

(State)

24A. DATE RECEIVED BY HEALTH DEPT.

MAY 1 1967

24B. NAME OF REGISTRAR

Robert E. Farber

24C. FUNERAL DIRECTOR

ADDRESS

Walter Dabrowski 1005 Dundalk Avenue

12

WALTON & BIRCH

WALTON & BIRCH

WALTON & BIRCH

WALTON & BIRCH

WALTON & BIRCH

WALTON & BIRCH

WALTON & BIRCH

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WALTON & BIRCH

1
2-246

67 4208

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 4208

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ERNEST S. ZEIGLER

2. DATE AND HOUR PRONOUNCED DEAD

April 27, 1967 8:20 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)40
99 St. Agnes Hospital

(DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland Baltimore Co.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore Owings Mills, Md.

D. STREET ADDRESS (If rural, give location)

11009 Reisterstown Road

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

July 18, 1898

9. AGE (In years
last birthday)

68

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Maintenance

10B. KIND OF BUSINESS OR INDUSTRY

Calvert Distillery Maryland

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Ernest Zeigler

14. MOTHER'S MAIDEN NAME

Fannie Baker

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

215-24-1380

17. INFORMANT

Mrs. Gertrude Zeigler

ADDRESS

11009 Reis. Rd.
Owings Mills, Md.

18. 4221 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

April 28, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

May 1, 1967

23C. NAME OF CEMETERY or CREMATORY

Pleasant Hill Meth. Cem. Owings Mills, Maryland.

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

MAY 1 1967

24B. NAME OF REGISTRAR

Robert E. Fairley, M.D.

24C. FUNERAL DIRECTOR

H. J. Eichhardt

ADDRESS

Owings Mills, Md.

WALLER PAPER

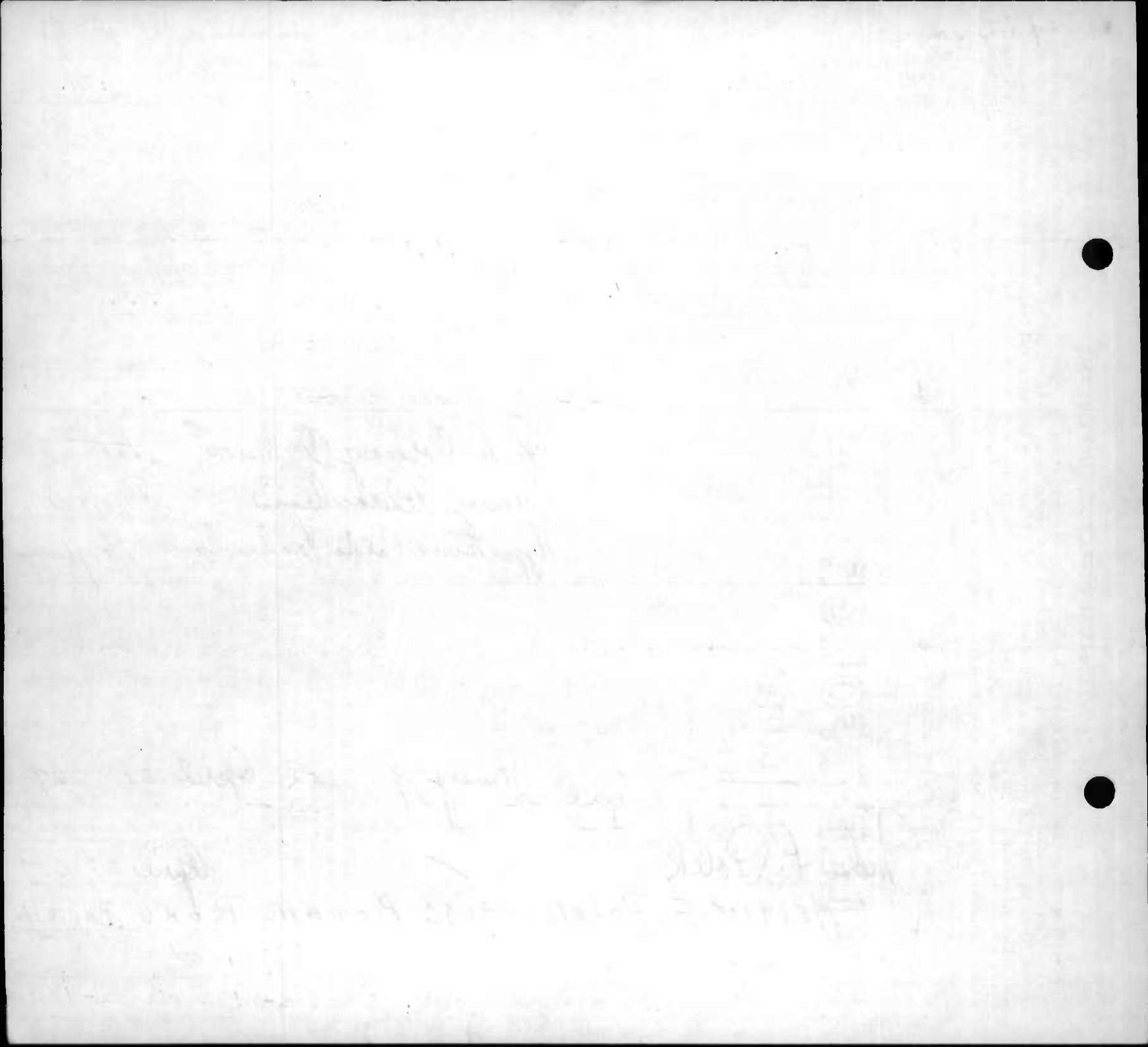
WALLER PAPER

4-2113-4

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | 67 4209 | | BALTIMORE CITY HEALTH DEPT. | | CERTIFICATE OF DEATH | | Registered No. 67 4209 | |
|--|---------|--|--|--|---------------------------------|--|--|----------------------------------|--|
| M.E. CASE NO. | | | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| | | | | Louis W. Teller | | April 24, 1967 5:30P. M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location) | | | | A. STATE | | B. COUNTY | | | |
| | | | | Maryland | | | | | |
| 44 Union Memorial Hospital | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | | | |
| | | | | Baltimore | | 8-01 | | | |
| D. STREET ADDRESS (If rural, give location) | | | | 2825 Brendan Avenue | | | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | |
| Male | White | Married | | Aug. 12, 1897 | 69 | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | | | |
| Bartender | | Jerry's Bar | | Baltimore, Maryland | | U.S.A. | | | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | | | |
| Frank Teller | | | | Lillian Schuder | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| Yes | | | | 215-07-5545 | | Theresa Teller-2825 Brendan Ave. | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) | | | | CAUSE OF DEATH | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) DUE TO | | | | stat | |
| | | | | (B) DUE TO | | | | 8 years | |
| | | | | (C) DUE TO | | | | 16 years | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| | | | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | | | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from January 3 1952 to April 21 1967, that (I) (we) last saw the deceased alive on April 21 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE, SIGNED | | | |
| Melvin F. Polek | | | | | | April 27, 1967 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | | | |
| MELVIN F. POLEK | | | | 3603 BELAIR ROAD, BALTO. MO. | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | | | |
| Burial | | 4-26-67 | | Holy Redeemer Cemetery | | Baltimore, Maryland | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | | | ADDRESS | |
| MAY 1 1967 | | Robert E. Tarkenton | | John C. Miller Inc. | | | | -6415 Belair Road-21206 | |



F-630

67 4210

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 67 4210

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JOHN P. FORD, SR.

2. DATE AND HOUR OF DEATH

April 28, 1967

7:30 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

Baltimore City Hospitals

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Md.

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore # 21224,

D. STREET ADDRESS (If rural, give location)

633 S. Conkling St.

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Mar. 19, 1887

9. AGE (In years
last birthday)

80

If Under 1 Yr.
Months DaysIf Under 24 Hrs.
Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

Real Estate

11. BIRTHPLACE (State or foreign country)

York, Pa.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Daniel H. Ford

14. MOTHER'S MAIDEN NAME

Catherine F. Kuehn

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

212-07-7882

17. INFORMANT

Katherine C. Ford

ADDRESS

Same.

18.

4-20-1 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) Coronary Thrombosis

None

(B) Arterio sclerotic C.V. Disease ?

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

None

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
WorkNot While
At Work

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from May 1957 to April 28 1967,
that (I) (we) last saw the deceased alive on April 27 1967 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Jason H. Gaskel

M.D.

Attending
Phys.Med.
DirectorStaff
Phys.

23B. DATE SIGNED

4-28-67

23C. PHYSICIAN'S
NAME (Type)

Jason H. Gaskel

M.D.

23D. ADDRESS

637 S. Conkling St. Balto., 21224, Md.

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

5-1-67.

24C. NAME OF CEMETERY or CREMATORY

Sacred Heart Cemetery

24D. LOCATION

(City, town, or county)

(State)

7401 German Hill Rd. Ba. Co., Md.

25A. DATE REC'D BY HEALTH DEPT.

MAY 1 1967

25B. NAME OF REGISTRAR

R. G. S. Ford

25C. FUNERAL DIRECTOR

Charles S. Seiler

901 S. Conkling St.

Balto., 21224, Md.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1-30-57

1957, 10, 15

1957, 10, 15

1957, 10, 15

1957, 10, 15

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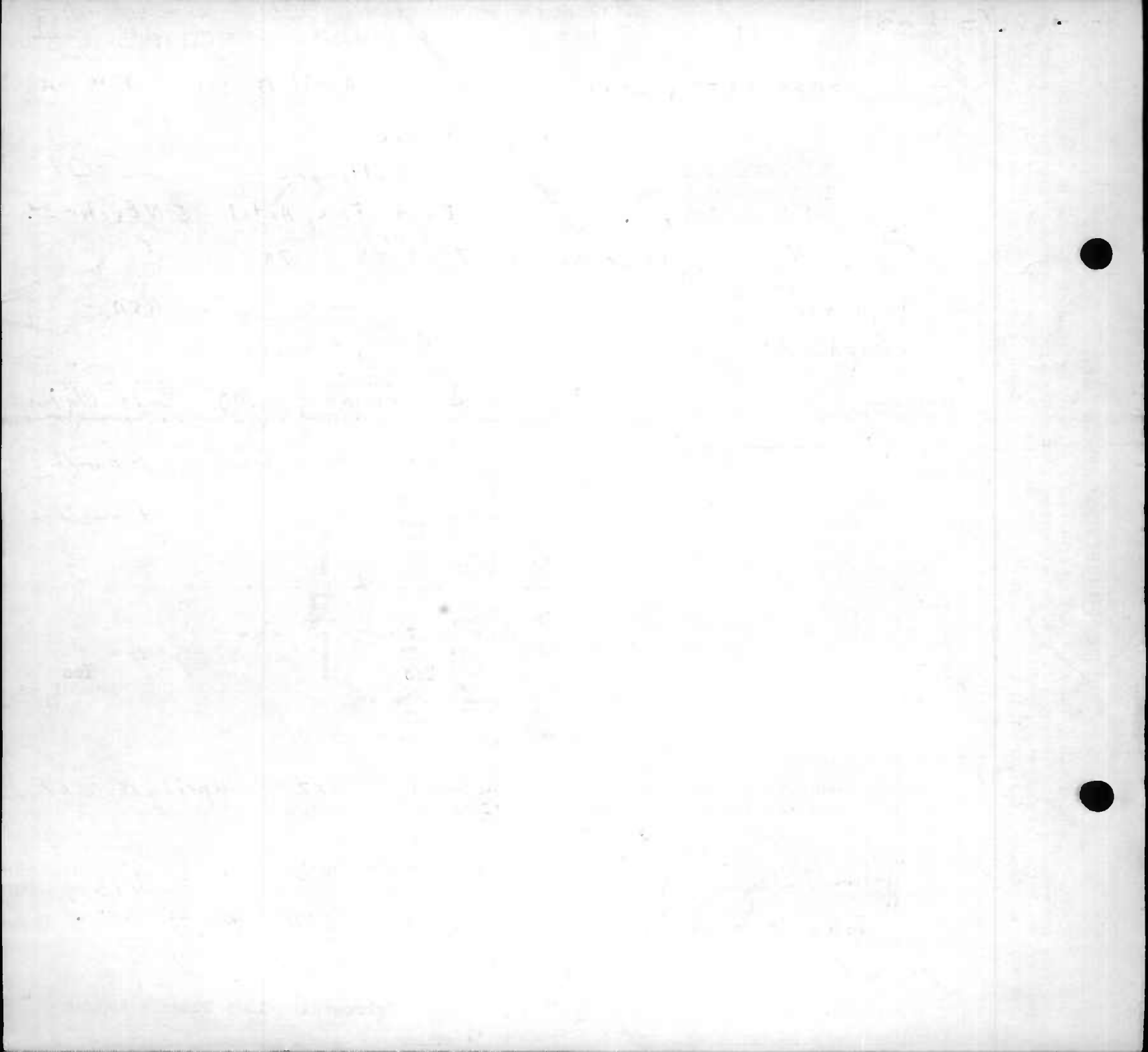
CERTIFICATE OF DEATH

Registered No.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|--|---|--|---|--|
| BIRTH NO. 67 4211 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 4211 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) <i>Gaphardt, Louis</i> | | 2. DATE AND HOUR OF DEATH
<i>April 13 1967 9:00 A.M.</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE <i>Maryland</i>
B. COUNTY | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<i>Baltimore</i> | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<i>31 BALTIMORE CITY HOSPITALS
4940 Eastern Avenue
Baltimore 21224, Md.</i> | | D. STREET ADDRESS (If rural, give location)
<i>East End Hotel 5 N Eyster St.</i> | | 5. SEX <i>♂</i> 6. RACE <i>W</i> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
<i>Never married</i> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>mechanic</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 8. DATE OF BIRTH <i>7/29/88</i> 9. AGE (In years last birthday) <i>79</i> | |
| 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | 13. FATHER'S NAME
<i>Gaphardt, ?</i> | |
| 14. MOTHER'S MAIDEN NAME
<i>?, Frances.</i> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>unknown</i> | | 16. SOCIAL SECURITY NO. <i>?</i> | |
| 17. INFORMANT
<i>J. Gregory</i> | | ADDRESS
<i>4940 Eastern Ave. Balt City Hosp.</i> | | 18. <i>181.01</i> CAUSE OF DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) | | (A) <i>Desiminated Bladder Ca.</i> | | INTERVAL BETWEEN ONSET AND DEATH
<i>6 months.</i> | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) <i>CVA</i> | | <i>4 months.</i> | |
| (C) | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
<i>Debilitation of age</i> | | | | | |
| 19A. DATE OF OPERATION <i>2</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<i>Yes</i> | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
<i>Yes</i> | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from <i>March 1967</i> to <i>April 13 1967</i> , that (I) (we) last saw the deceased alive on <i>April 12 1967</i> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) <input type="checkbox"/> (I) (did not) view the body after death. | | | |
| 23A. SIGNATURE
<i>John G. Gregory MD</i> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
<i>April 13</i> | |
| 23C. PHYSICIAN'S NAME (Type)
<i>John G. Gregory</i> | | M.D. 23D. ADDRESS
<i>Balt. City Hosp. 4940 Eastern Ave.</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 24B. DATE
<i>4-27-67</i> | | 24C. NAME OF CEMETERY or CREMATORY
<i>Sacred Heart</i> | |
| 24D. LOCATION (City, town, or county) (State)
<i>Balt. Md.</i> | | 25A. DATE REC'D BY HEALTH DEPT.
<i>MAY 1 1967</i> | | 25B. NAME OF REGISTRAR
<i>Robert E. Taylor</i> | |
| 25C. FUNERAL DIRECTOR
<i>Walter Dabrowski</i> | | ADDRESS
<i>1005 Dundalk Avenue</i> | | | |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 4212

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ROLAND HAWKINS

2. DATE AND HOUR PRONOUNCED DEAD

4-28-67 11:20 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

39 PROVIDENT HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

MARYLAND

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

BALTIMORE

D. STREET ADDRESS (If rural, give location)

604 CUMBERLAND

5. SEX

MALE

6. RACE

NEGRO

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

single

8. DATE OF BIRTH

3-7-46

9. AGE (In years
(last birthday))

21

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

Wm. Hawkins

14. MOTHER'S MAIDEN NAME

Francis Kent

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Wm. Hawkins 604 Cumberland St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

GUNSHOT WOUND OF CHEST

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

YES

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

STREET

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

1300 BLOCK N. CALHOUN ST.

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
4 28 67 11:20

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

UNKNOWN

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☒

DATE SIGNED

ACTUAL
SIGNATURE

EXAMINER'S

NAME (Type)

RUSSELL S. FISHER, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

4-29-67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

5-2-67

23C. NAME OF CEMETERY or CREMATORY

Mt. Auburn Cem.

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

MAY 1 1967

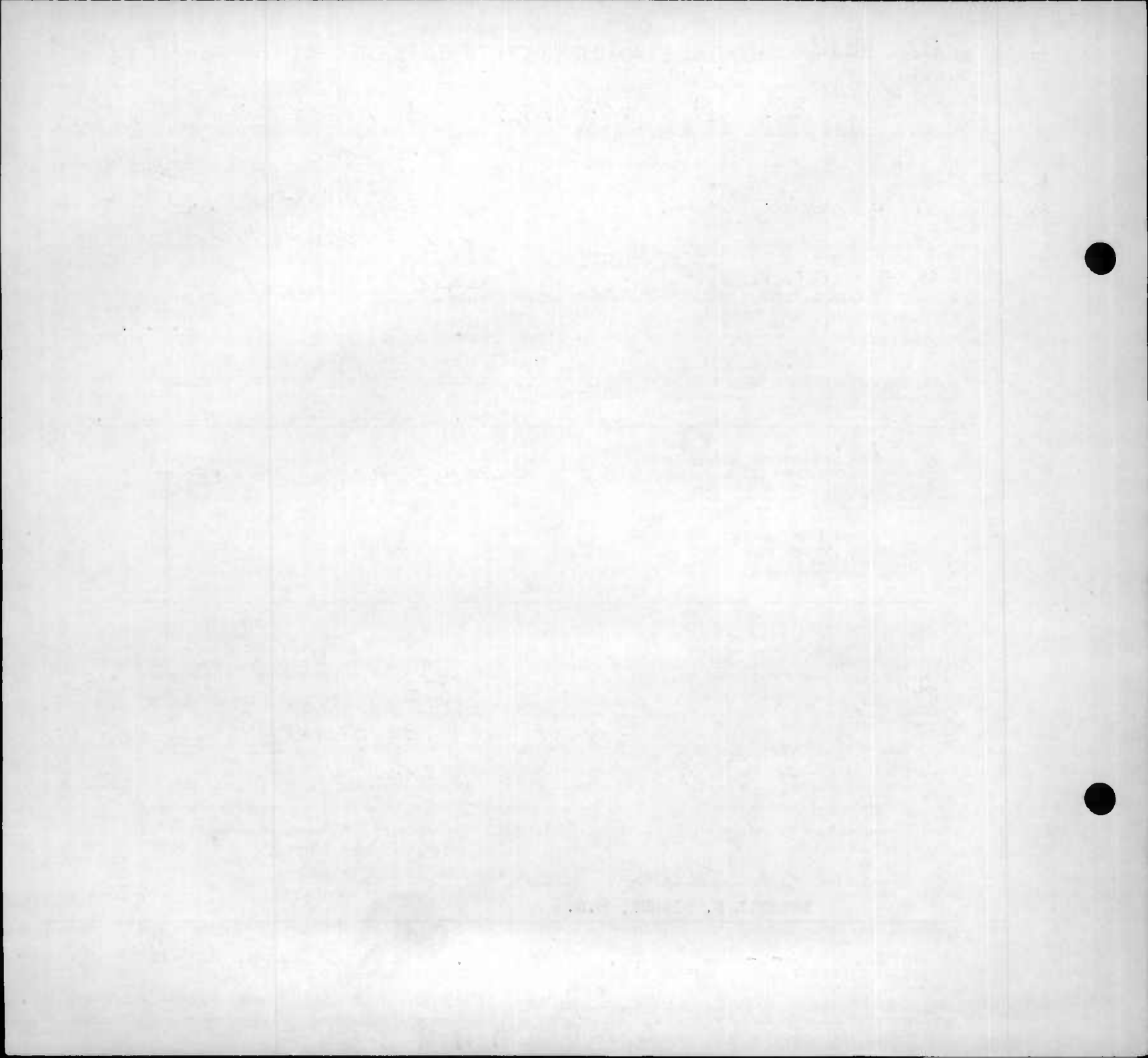
24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

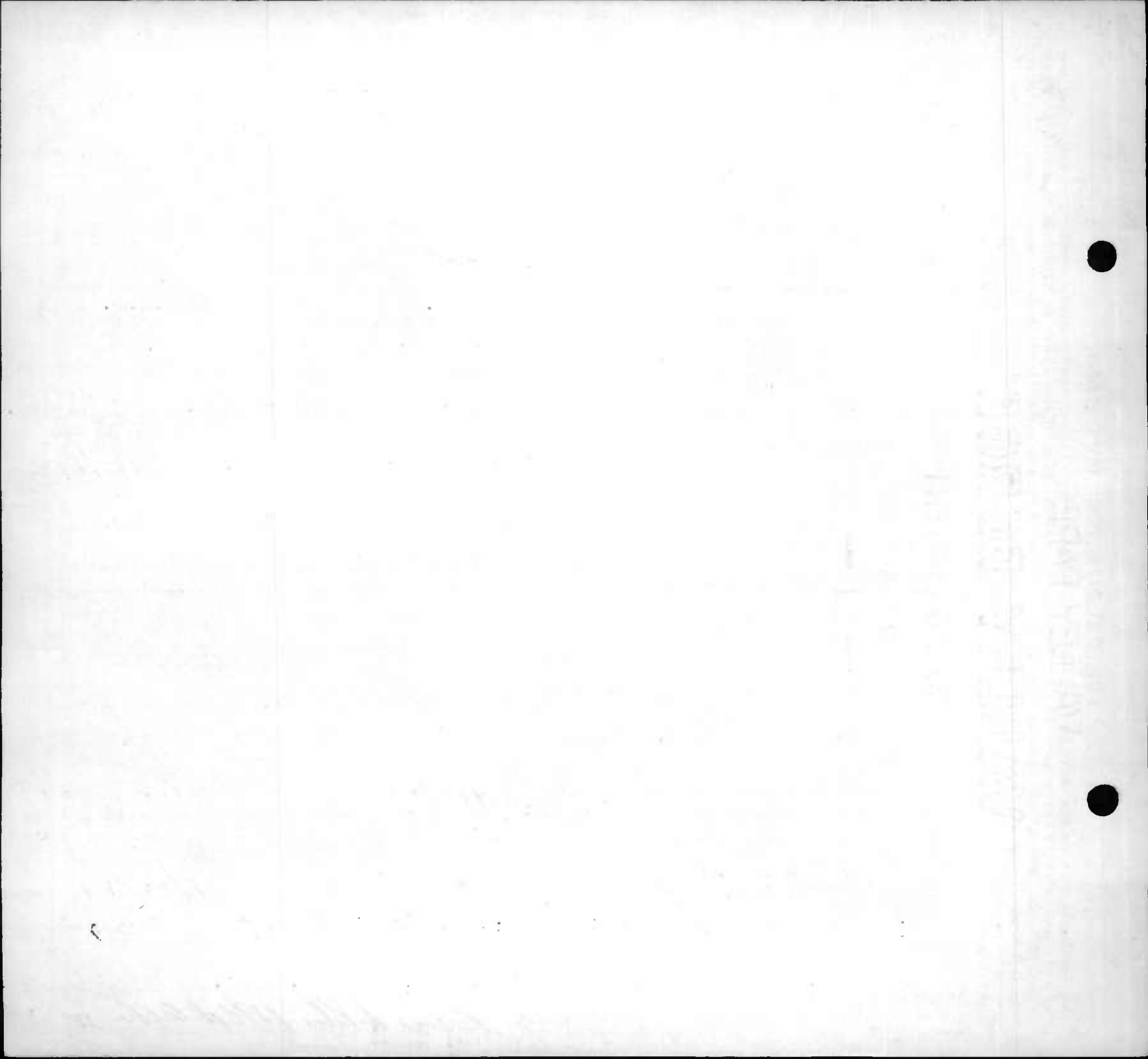
ADDRESS

Kelson Funeral Home 1348 Calhoun St.



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

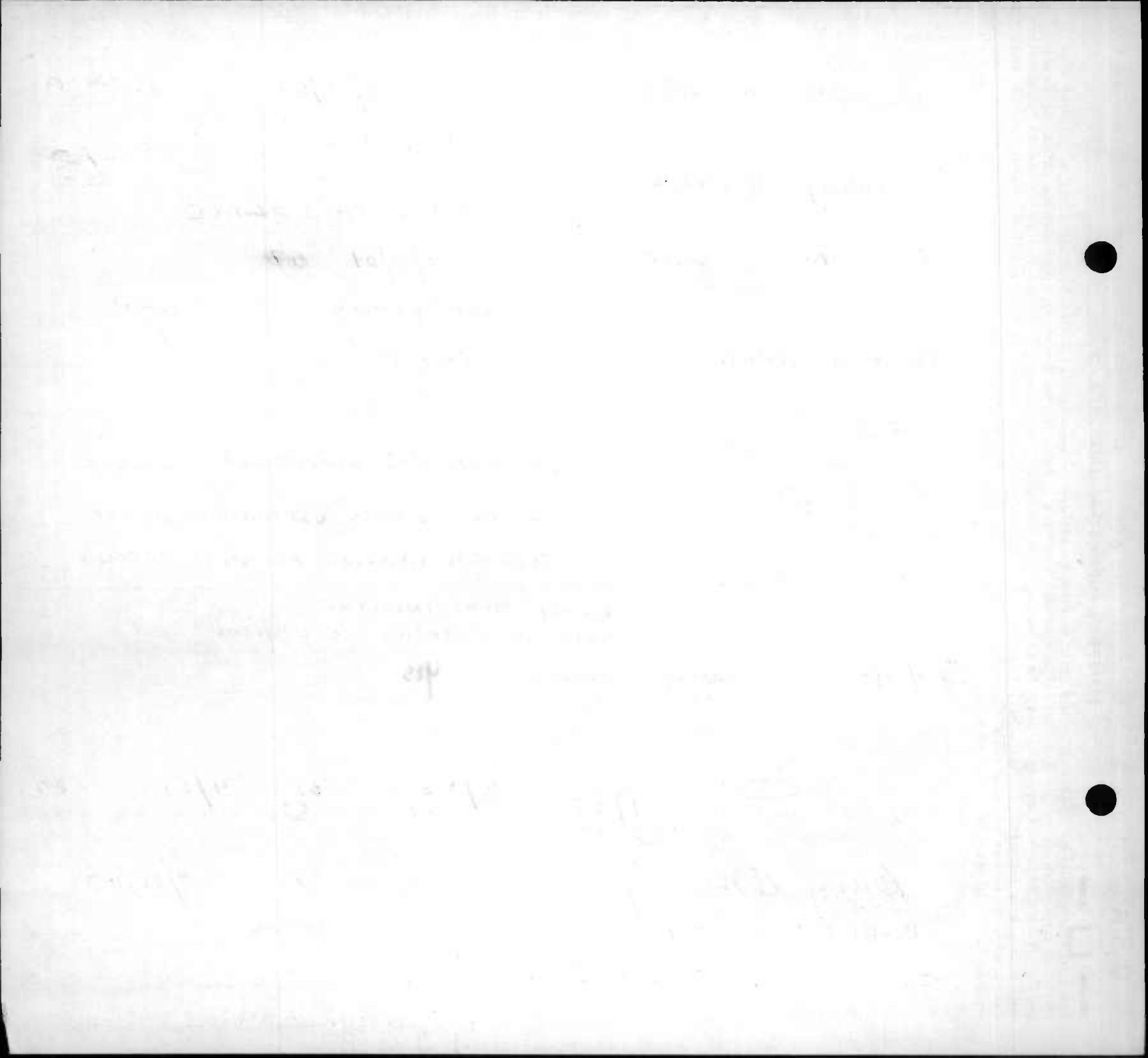
| BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 4213 | |
|--|-------------------------|---|---|
| BIRTH NO. 67 4213 | | M.E. CASE NO. | |
| 1. NAME OF DECEASED
(Type or Print) Catherine Gaither | | 2. DATE AND HOUR OF DEATH
4-28-67 10:05 M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND
Bolton Hill Nursing Center
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE Maryland
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1100 Calhoun Street | |
| 5. SEX
Female | 6. RACE
White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
Divorced | 8. DATE OF BIRTH
1-1-97 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | 9. AGE (In years last birthday) 70 |
| 11. BIRTHPLACE (State or foreign country)
Md. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Alfred Fountain | | 14. MOTHER'S MAIDEN NAME
Aliza White | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
219-307174 | 17. INFORMANT
Benjamin Gaither ADDRESS
2824 Rosaland Ave. |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
260X I | | CAUSE OF DEATH
(A) Cerebral Vascular accident, etc. 4/17/67
(B) Hypertensive C.V. disease years
(C) diabetes years | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II | | INTERVAL BETWEEN ONSET AND DEATH | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 4/11/67 19 to 4/28 1967, that (I) (we) last saw the deceased alive on 4/28 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE
ALLAN H. MACHT M.D. | | 23B. DATE SIGNED
4/28/67 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS
2 E. READ ST 21202 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
5-2-67 | |
| 24C. NAME OF CEMETERY or CREMATORY
Mt. Calvary Cem. | | 24D. LOCATION (City, town, or county) (State)
Balto. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 1 1967 | | 25B. NAME OF REGISTRAR
Robert E. Fagerman | |
| 25C. FUNERAL DIRECTOR
George J. Kline | | ADDRESS
1348 N. Calhoun St | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

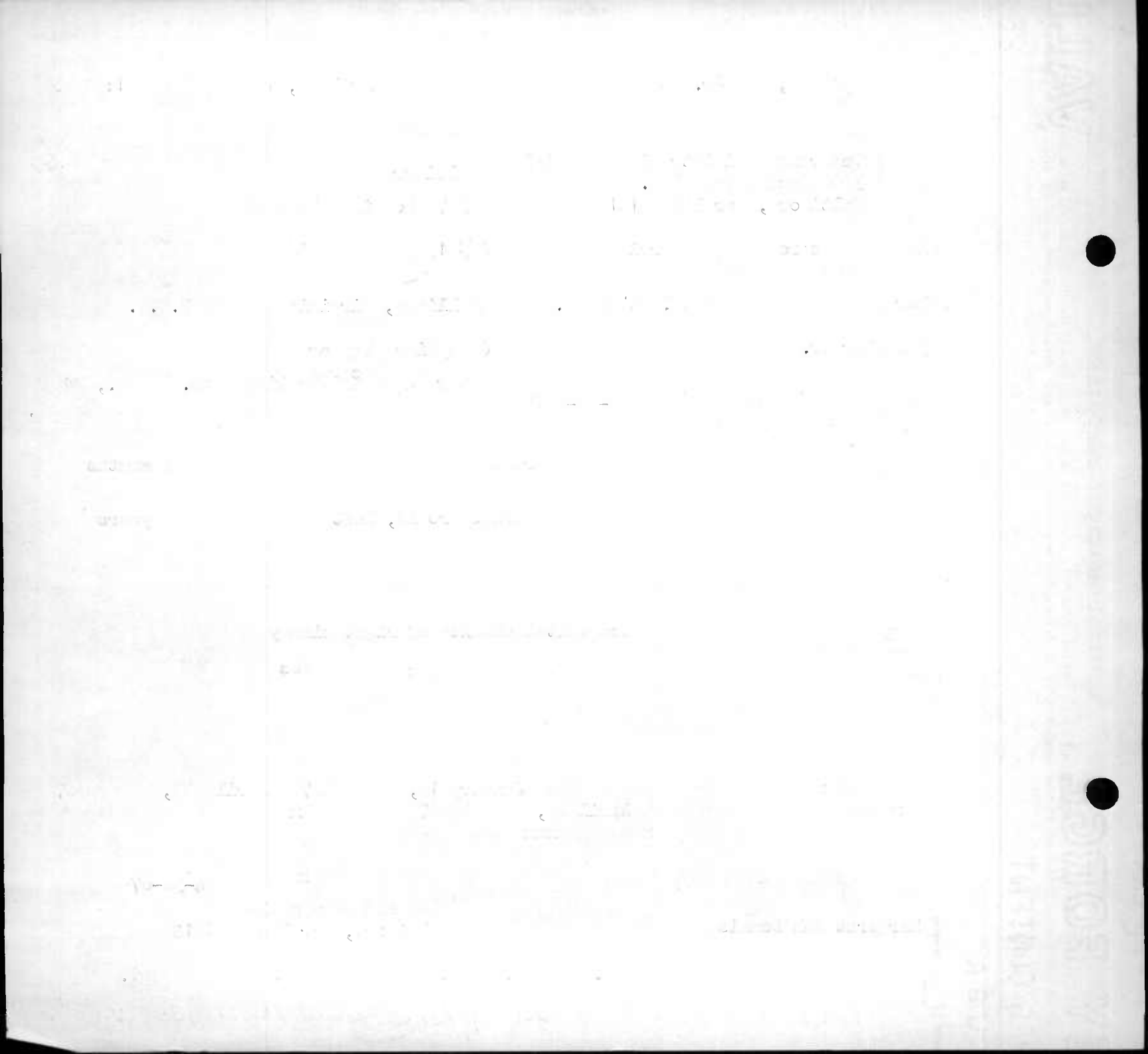
| | | | | | |
|---|--------------|---|---|--|--|
| BIRTH NO. 67 4214 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 4214 | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED
(Type or Print) WILLIAM REED | | | 2. DATE AND HOUR OF DEATH
4/25/67 10 40 A.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY BALTIMORE | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
37 MERCY HOSPITAL | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE 14-03
D. STREET ADDRESS (If rural, give location)
1918 EUTAW PLACE | | |
| 5. SEX
M | 6. RACE
N | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
NEVER MARRIED | 8. DATE OF BIRTH
12/21/09 | 9. AGE (In years last birthday)
57 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. |
| 13. FATHER'S NAME
THOMAS REED | | | 14. MOTHER'S MAIDEN NAME
EMMA ? | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH
(A) PROBABLE G-I HEMORRHAGE DUE TO
(B) PROBABLE STRESS ULCERATION DUE TO
(C) CEREBRAL VASCULAR ACCIDENT | | INTERVAL BETWEEN ONSET AND DEATH
ACUTE
ACUTE
CHRONIC |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | URINARY TRACT INFECTION
MULTIPLE ARTERIAL OCCLUSIONS | | |
| 19A. DATE OF OPERATION
4/17/67 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
RESPIRATORY EMBOUSMENT | | 20A. AUTOPSY? (Yes or No)
YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
NO | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (X) (his hospital) attended the deceased from 3/22 1967 to 4/25 1967, that (X) (we) lost saw the deceased alive on 4/25 1967 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) did (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Barry Ominsky | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
4/25/67 |
| 23C. PHYSICIAN'S NAME (Type)
BARRY OMINSKY | | | 23D. ADDRESS
MERCY HOSPITAL | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
4-29-67 | 24C. NAME OF CEMETERY or CREMATORY
Mt. Auburn Cem. | | 24D. LOCATION (City, town, or county) (State)
Balto. Md. |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 1 1967 | | 25B. NAME OF REGISTRAR
Robert E. Fairman | | 25C. FUNERAL DIRECTOR ADDRESS
Kelson Funeral Home 1348 CARROLL | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | Registered No. 67 4215 | |
|--|---------------|--|-------------------------|---|-------------------------------|--|--|
| BIRTH NO. 67 4215 | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) TAYLOR, Guy Jr. | | 2. DATE AND HOUR OF DEATH April 29, 1967 1:50 P M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION Veterans Administration Hospital 27 3900 Loch Raven Blvd. Baltimore, Maryland 21218 | | | | A. STATE Maryland | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | |
| | | | | D. STREET ADDRESS (If rural, give location) 3307 Bloomingdale Road | | | |
| 5. SEX Male | 6. RACE Negro | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 4/5/19 | 9. AGE (In years lost birthday) 48 | 10. Under 1 Yr. Months: Days: | 11. Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10B. KIND OF BUSINESS OR INDUSTRY Beth. Steel Co. | | 11. BIRTHPLACE (State or foreign country) Rawlings, Virginia | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Guy Taylor Sr. | | | | 14. MOTHER'S MAIDEN NAME Josephine Taylor | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 2/4/43 to 7/20/43 | | 16. SOCIAL SECURITY NO. 229-14-8812 | | 17. INFORMANT Records Veterans Administration Hosp. Balto., Md | | ADDRESS 3307 Bloomingdale Rd. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES | | | | (A) Uremia DUE TO | | 4 months | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) Hydronephrosis, left DUE TO | | years | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Congenital absence of right kidney | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from January 16, 19 67 to April 29, 1967, that (I) (we) last saw the deceased alive on April 29, 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Margaret Ann Dennis M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | | | 23B. DATE SIGNED 4-30-67 | |
| 23C. PHYSICIAN'S NAME (Type) Margaret Ann Dennis | | | | 23D. ADDRESS 3900 Loch Raven Blvd Baltimore, Maryland 21218 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 4-30-67 | | 24C. NAME of CEMETERY or CREMATORY Balto. Nat'l. Cem. | | 24D. LOCATION (City, town, or county) Balto. (State) Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. MAY 1 1967 | | 25B. NAME OF REGISTRAR Robert E. Farkas | | 25C. FUNERAL DIRECTOR Nelson Funeral Home | | ADDRESS 1348 N. Calhoun | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 4216 | |
|--|-----------------|--|--|---|---|
| BIRTH NO. 67 4216 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | Carrie L. Dean | | April 27, 1967 2:00 A. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location)

90 House In The Pines Nursing Home
2525 West Belvedere Avenue | | | A. STATE
Md. | | |
| | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | | |
| | | | D. STREET ADDRESS (If rural, give location)
25 West Chase Street | | |
| 5. SEX
Female | 6. RACE
Cau. | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widow | 8. DATE OF BIRTH
Oct. 4, 1892 | 9. AGE (In years last birthday)
74 | If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Self-employed | | 10B. KIND OF BUSINESS OR INDUSTRY
Cosmetics | | 11. BIRTHPLACE (State or foreign country)
Denton, Caroline County, Md. | |
| 13. FATHER'S NAME
Charles Dean | | | 14. MOTHER'S MAIDEN NAME
Lilly Jopp | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
220-48-1743 | | 17. INFORMANT
Mrs. Elizabeth Brady, 5322 Beaufort Ave. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

260X I

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | CAUSE OF DEATH
(A) DUE TO
CVA to left hemiparesis | | INTERVAL BETWEEN ONSET AND DEATH |
| | | | (B) DUE TO | | |
| | | | (C) Diabetes mellitus HASCKD & recent M.I. | | |
| | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 0 | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from April 2nd 1967 to April 27th 1967 that (I) (we) last saw the deceased alive on April 26 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (we) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
F. W. Fromm, M.D. | | | | 23B. DATE SIGNED
4/28/67 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS
One East University Parkway | | | |
| | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
5/1/67 | | 24C. NAME OF CEMETERY or CREMATORY
Cathedral Cemetery | |
| | | | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 1 1967 | | 25B. NAME OF REGISTRAR
R. E. Taylor | | 25C. FUNERAL DIRECTOR
G. Kerman Lemmon | |
| | | | | ADDRESS
4611 Park Heights Ave. | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | BIRTH NO. 67 4217 | | CERTIFICATE OF DEATH | | Registered No. 67 4217 | |
|---|---------------------|---|--------------------------------------|--|----------------------------|--|-----------------------------|------------------------|--|
| 1. NAME OF DECEASED
(Type or Print) BEDNARSKI MRS MARY (Maryanna) | | | | 2. DATE AND HOUR OF DEATH
4. 28. 1967 4:30 A.M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
35 CHURCH HOME & HOSP | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD. B. COUNTY 425 S. DURHAM ST. (31) Maryland
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore 2-002
D. STREET ADDRESS (If rural, give location)
425 S. DURHAM ST. (31) | | | | | |
| 5. SEX
F | 6. RACE
W | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
WIDOW | 8. DATE OF BIRTH
10. 5. 89 | 9. AGE (In years last birthday)
77 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Charwoman | | 10B. KIND OF BUSINESS OR INDUSTRY
Office Building | | 11. BIRTHPLACE (State or foreign country)
POLAND | | 12. CITIZEN OF WHAT COUNTRY?
AMR. U.S.A. | | | |
| 13. FATHER'S NAME
LEO SMERDZINSKI | | | | 14. MOTHER'S MAIDEN NAME
Ramona Olesinski | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
- | | 16. SOCIAL SECURITY NO.
215-10-1704 | | 17. INFORMANT
Mr. Leo Bednarski, 405 E. Clement St.
Church Home & Hosp. | | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
35 IX I
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
cerebrovascular accident | | | | CAUSE OF DEATH
(A) DUE TO
one day
(B) DUE TO
sclerosis of cerebral vessels
(C) DUE TO
hypertension | | INTERVAL BETWEEN ONSET AND DEATH
many years | | | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
II | | | | | | | | | |
| 19A. DATE OF OPERATION
D | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 4. 27. 1967 to 4. 28. 1967 , that (I) (we) last saw the deceased alive on 4. 28. 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
K. M. Anandiah M.D. | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
4/28/67 | | | |
| 23C. PHYSICIAN'S NAME (Type)
K.M. ANANDAIAH M.D. | | | | 23D. ADDRESS
Church home & hospital Baltimore | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
5/1/67 | | 24C. NAME OF CEMETERY or CREMATORY
St. Stanislaus | | 24D. LOCATION (City, State)
Baltimore, Maryland | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 1 1967 | | 25B. NAME OF REGISTRAR
R. J. G. F. J. J. | | 25C. FUNERAL DIRECTOR
M. F. SADOWSKI & SONS | | ADDRESS
1808 EASTERN AVENUE | | | |

10-10-72

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 4218 | |
|--|-------------------------|---|------------------------------------|---|---|
| BIRTH NO. 67 4218 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) <i>Wright, Patrick</i> | | 2. DATE AND HOUR OF DEATH
<i>4/27/67 9:45 PM M.</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <i>Maryland</i>
B. COUNTY <i>Baltimore</i> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<i>Baltimore</i> | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<i>Lincoln Memorial Nursing Home</i>
<i>90 277 Carey St Baltimore, Md.</i> | | D. STREET ADDRESS (If rural, give location)
<i>277 Carey Street</i> | | 18-02 | |
| 5. SEX
<i>MALE</i> | 6. RACE
<i>Negro</i> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<i>Widowed</i> | 8. DATE OF BIRTH
<i>1/19/02</i> | 9. AGE in years
(last birthday) <i>65</i> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>unknown</i> | | 10B. KIND OF BUSINESS OR INDUSTRY
<i>retired</i> | | 11. BIRTHPLACE (State or foreign country)
<i>unknown</i> | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME
<i>unknown</i> | | 14. MOTHER'S MAIDEN NAME
<i>unknown</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>unknown</i> | | 16. SOCIAL SECURITY NO.
<i>unknown</i> | | 17. INFORMANT
<i>Lincoln Memorial Nursing Home</i>
<i>277 Carey Street Baltimore</i> | |
| 18. <i>527.21</i> | | CAUSE OF DEATH | | ADDRESS
<i>277 Carey Street Baltimore</i> | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) <i>Acute pulmonary Edema</i> | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) _____ | | | |
| (C) _____ | | | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
<i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>12/15 1966</i> to <i>4/27 1967</i> , that (I) (we) last saw the deceased alive on <i>4/27 1967</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<i>Thomas J. Deenarine, M.D.</i> | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
<i>4/27/67</i> | |
| 23C. PHYSICIAN'S NAME (Type)
<i>Thomas J. Deenarine</i> | | M.D. 23D. ADDRESS
<i>930 W. Haverhill St</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 24B. DATE
<i>4/28/67</i> | | 24C. NAME OF CEMETERY or CREMATORY
<i>mt Calvary</i> | |
| 24D. LOCATION (City, town, or county) (State)
<i>Baltimore Maryland</i> | | 25A. DATE RECEIVED
<i>APR 27 1967</i> | | 25B. NAME OF REGISTRAR
<i>Robert E. Jackson</i> | |
| 25C. FUNERAL DIRECTOR
<i>Robert E. Jackson</i> | | ADDRESS
<i>2302 W. North Ave Baltimore Md</i> | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | | | | |
|---|--|---|--|--|---|--|--|--|--|---|--|-----------------------------|--|--|
| BIRTH NO. 67 4219 | | | | | CERTIFICATE OF DEATH | | | | | Registered No. 67 4219 | | | | |
| 1. NAME OF DECEASED
(Type or Print) ROBEY FRANCES E | | | | | 2. DATE AND HOUR OF DEATH
4/28/67 7:30a.m. | | | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) | | | | | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
UNIVERSITY HOSPITAL | | | | | A. STATE
MD. | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE | | | | |
| (If not in hospital or institution, give street address or location) | | | | | B. COUNTY | | | | | D. STREET ADDRESS (If rural, give location)
1453 PATAPSCO STREET | | | | |
| 5. SEX
F | | 6. RACE
W | | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
MARRIED | | 8. DATE OF BIRTH
10-3-18 | | 9. AGE (In years last birthday)
48 | | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWIFE | | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | | | 11. BIRTHPLACE (State or foreign country)
Md. | | | | |
| 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | | | | | 13. FATHER'S NAME
CHARLES F. GRAMS | | | | | 14. MOTHER'S MAIDEN NAME
REHMERT, Catherine | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | | 16. SOCIAL SECURITY NO. | | | | | 17. INFORMANT ADDRESS
Richard E Robey, 1453 PatapSCO St. | | | | |
| 18. 410X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | CAUSE OF DEATH
(A) Post-operative Shock & Renal Shutdown following
(B) Mitral Valve Replacement
(C) § | | | | | INTERVAL BETWEEN ONSET AND DEATH
12 hrs. | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | | | | |
| 19A. DATE OF OPERATION
4/27/67 | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
Mitral Heart disease | | | | | 20A. AUTOPSY? (Yes or No)
NO | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 4-23-1967 to 4-28-1967 , that (I) (we) last saw the deceased alive on 4-28-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | | | | |
| 23A. SIGNATURE
B. N. IRANI | | | | | M.D. <input type="checkbox"/> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | | | 23B. DATE SIGNED
4/28/67 | | | | |
| 23C. PHYSICIAN'S NAME (Type)
B. N. IRANI | | | | | 23D. ADDRESS
UNIVERSITY HOSPITAL | | | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | | | | 24B. DATE
5-1-67 | | | | | 24C. NAME of CEMETERY or CREMATORY
Balto. National Cemetery | | | | |
| 24D. LOCATION (City, town, or county) (State)
Frederick Ave., Balto. Md. | | | | | 25A. DATE REC'D BY HEALTH DEPT.
MAY 1 1967 | | | | | 25B. NAME OF REGISTRAR
John E. Taylor | | | | |
| 25C. FUNERAL DIRECTOR ADDRESS
Flynn & Blanding, 1422 Light St. | | | | | 25D. 4227 | | | | | | | | | |

Wagon

Richard F. Robert 1882

24

John A. Smith

67 4220

BALTIMORE CITY HEALTH DEPARTMENT

67 4220

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

BILLY JOE BRAGG

2. DATE AND HOUR PRONOUNCED DEAD

4-15-67

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

704 E. BIDDLE STREET - Apt. 1-A

D. STREET ADDRESS (If rural, give location)

704 E. Biddle Street Apt. #1-A

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

4/10-33

9. AGE (In years
last birthday)

34-10-34

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Labor

10B. KIND OF BUSINESS OR INDUSTRY

Bleach Mill

11. BIRTHPLACE (State or foreign country)

W. Va.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Herbert F. Bragg

14. MOTHER'S MAIDEN NAME

Laura Crowford

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

Laura M. Crowford

ADDRESS

213 Pleasant, AVE

18.

CAUSE OF DEATH

Hinton W. Va.

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Fatty alteration of liver
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Partial

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

WERNER U. SPITZ, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

4-16-67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

4/30-1967

23C. NAME of CEMETERY or CREMATORY

23D. LOCATION

(City, town, or county)

(State)

Hinton W Va.

24A. DATE REC'D BY HEALTH DEPT.

MAY 1 1967

24B. NAME OF REGISTRAR

Robert E. Farkas

24C. FUNERAL DIRECTOR

Frank A. Seitz 814 N. 36th St
Baltimore Md

WALLEY FORGE

25% DAY CONTRACT

U.S.

Robert B. J.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | Registered No. 67 4221 | |
|--|------------------------|--|---|--|--|--|--|
| BIRTH NO. 67 4221 | | M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) BENJAMIN GOLDSTEIN | | 2. DATE AND HOUR OF DEATH
27 APRIL 67 1 12 P M | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
91 LEINORNE NURSING HOME | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE MARYLAND
B. COUNTY BALTIMORE
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE
D. STREET ADDRESS (If rural, give location) 5122 QUEENSBERRY AVE. | | | |
| 5. SEX
MALE | 6. RACE
CAUC | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
WIDOW | 8. DATE OF BIRTH
8-13-56 | 9. AGE (In years last birthday)
77 | 10. CITIZEN OF WHAT COUNTRY?
AMERICAN | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
OFFICE | | | 10B. KIND OF BUSINESS OR INDUSTRY
STEEL | | 11. BIRTHPLACE (State or foreign country)
RUSSIA | | |
| 13. FATHER'S NAME
JOSEPH GOLDSTEIN | | | 14. MOTHER'S MAIDEN NAME
REBECCA KANTOR | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | | 16. SOCIAL SECURITY NO.
218-05-0421A | | 17. INFORMANT
LEINORNE RECORDS | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
CAUSE OF DEATH
BRONCHOPNEUMONIA
PULMONARY EMBOLIZATION
THROMBOPHLEBITIS - LEGS | | | | INTERVAL BETWEEN ONSET AND DEATH
3 HOURS
ONE MONTH | | | |
| 18. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.
Anterior chest wall cardiac aneurysm
Occult Hemorrhage
PULMONARY EMPHYSEMA + FIBROSIS | | | | ONE MONTH
YEARS | | | |
| MEDICAL CERTIFICATION | | | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (A) (this hospital) attended the deceased from Nov 20 19 57 to APRIL 27 19 67 .
that (B) (we) lost saw the deceased alive on APRIL 27 19 67 and that in (C) (our) opinion death occurred on the date and hour and from the causes stated above. (D) (we) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
Michael L. Levin | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
27 APRIL 67 | |
| 23C. PHYSICIAN'S NAME (Type)
Michael L. Levin | | | | 23D. ADDRESS
SINAI HOSPITAL of Baltimore | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
4/28/67 | | 24C. NAME OF CEMETERY or CREMATORY
SHAAREI ZION | | 24D. LOCATION (City, town, for county) (State)
BALTIMORE, MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 1 1967 | | 25B. NAME OF REGISTRAR
Robert E. Tabor | | 25C. FUNERAL DIRECTOR ADDRESS
SOL LEVINSON & BROS. INC., 6010 REIST., RD. | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | | | | | | | | | Registered No. 67 4222 | |
|--|---------------------|--|--|--|--|--|--|---|--|--|--|
| BIRTH NO. 67 4222 | | | | | | | | | | | |
| M.E. CASE NO. | | | | | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) EDITH L. NORMAN | | 2. DATE AND HOUR OF DEATH
4-25-67 2³⁰ P.M. | | | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD B. COUNTY BALTO | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
Andersen Nursing Home | | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTO | | | | | |
| (If not in hospital or institution, give street address or location) | | | | | | D. STREET ADDRESS (If rural, give location)
4416 Old Frederick Rd. | | | | | |
| 5. SEX
F | 6. RACE
W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
Widowed | | 8. DATE OF BIRTH
9-17-84 | | 9. AGE (In years last birthday)
82 | | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | | | 10B. KIND OF BUSINESS OR INDUSTRY
at home | | | | 11. BIRTHPLACE (State or foreign country)
MD | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
George Hatton | | | | | | 14. MOTHER'S MAIDEN NAME
Mary Ann | | | | | |
| 15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Robert S. Barranco | | | |
| | | | | | | ADDRESS
Severna Park, Md. | | | | | |
| 18. 782.4 I | | | | | | CAUSE OF DEATH | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) | | | | | | (A) Cardiac Failure | | | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | (B) DUE TO | | | | | |
| | | | | | | (C) DUE TO | | | | | |
| II | | | | | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| | | | | | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| | | | | | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| | | | | | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Sept 14 1963 to April 25 1967 , that (I) (we) last saw the deceased alive on April 25 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE
George E. Shannon | | | | | | | | M.D. <input type="checkbox"/> Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
April 26, 1967 | |
| 23C. PHYSICIAN'S NAME (Type)
GEORGE E. SHANNON | | | | | | | | 23D. ADDRESS
412 Medical Arts Building | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE
4/28/67 | | 24C. NAME of CEMETERY or CREMATORY
London Park | | | | 24D. LOCATION (City, town, or county) (State)
BALTO MD | | | |
| Burial | | | | | | | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 1 1967 | | | | 25B. NAME OF REGISTRAR
Robert S. Barranco | | | | 25C. FUNERAL DIRECTOR
Robert S. Barranco | | | |
| | | | | | | | | ADDRESS
Severna Park, Md. | | | |

George Smith
Housing at home
to be arranged
Lester and Mary Ann
11/24/1914

George Smith
Housing at home
to be arranged
Lester and Mary Ann
11/24/1914

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 67 4223 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 4223 | |
|---|-------------------------|--|---|--|---|
| M.E. CASE NO. | | | CERTIFICATE OF DEATH | | |
| 1. NAME OF DECEASED
(Type or Print) <u>Harvey Tracey, Sr.</u> | | | 2. DATE AND HOUR OF DEATH
<u>4/28/67</u> <u>10 45 A.</u> M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <u>Md.</u> B. COUNTY <u>Baltimore Co.</u> | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location)
<u>House in the Pines</u>
<u>2525 W. Belvedere Ave.</u> | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>Lutherville</u> <u>53-00</u> | | |
| D. STREET ADDRESS (If rural, give location)
<u>331 W. Seminary Ave.</u> | | | | | |
| 5. SEX
<u>Male</u> | 6. RACE
<u>White</u> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<u>Married</u> | 8. DATE OF BIRTH
<u>Febr. 9/1889</u> | 9. AGE (In years last birthday)
<u>78</u> | If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work during most of working life, even if retired)
<u>Signal Maintainer</u> | | | 11. BIRTHPLACE (State or foreign country)
<u>Baltimore Co., Md.</u> | | |
| 10B. KIND OF BUSINESS OR INDUSTRY
<u>P. R. R.</u> | | | 12. CITIZEN OF WHAT COUNTRY?
<u>U. S. A.</u> | | |
| 13. FATHER'S NAME
<u>Daniel Tracey</u> | | | 14. MOTHER'S MAIDEN NAME
<u>Susan Kramer</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no, or unknown) (If yes, give war or dates of service)
<u>No</u> | | | 16. SOCIAL SECURITY NO.
<u>717-07-6211</u> | | |
| 17. INFORMANT
<u>Mrs. Mahel M. Tracey</u> | | | ADDRESS
<u>331 W. Seminary Ave., Lutherville, Md.</u> | | |
| 18. <u>420.1 I</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)
<u>acute myocardial infarction</u>
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
<u>arterio-sclerotic evd.</u> | | | CAUSE OF DEATH
(A) <u>acute myocardial infarction</u>
(B) <u>arterio-sclerotic evd.</u>
(C) <u>arterio-sclerotic evd.</u> | | |
| 19A. DATE OF OPERATION
<u>0</u> | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | |
| 20A. AUTOPSY? (Yes or No) | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | |
| 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Mar 18 1967</u> to <u>April 28 1967</u> , that (I) (we) last saw the deceased alive on <u>April 28 1967</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>Richard J. Thomas</u> | | | 23B. DATE SIGNED
<u>4/28/67</u> | | |
| 23C. PHYSICIAN'S NAME (Type)
<u>Richard J. Thomas</u> | | | 23D. ADDRESS
<u>1000 N. E. St.</u> | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | | 24B. DATE
<u>May 1, 1967</u> | | |
| 24C. NAME OF CEMETERY OR CREMATORY
<u>Middletown Cemetery</u> | | | 24D. LOCATION (City, town, or county) (State)
<u>Freeland, Md.</u> | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>MAY 1 1967</u> | | | 25B. NAME OF REGISTRAR
<u>Robert E. Taylor</u> | | |
| 25C. FUNERAL DIRECTOR
<u>John J. Hartenstein</u> | | | ADDRESS
<u>New Freedom, Pa.</u> | | |

January 1851

Spencer's
No. 10
Daniel Tracy
Spencer's

Baltimore
331 N. Seminary Ave.
Feb. 1851
Baltimore Co. Md. 21.24
Susan K. Tracy

Baltimore
331 N. Seminary Ave.
Feb. 1851
Baltimore Co. Md. 21.24

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|--------------|--|--|--|---------------------------------------|
| BIRTH NO. 67 4224 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 4224 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) LIEBECK, CARL HENRY | | 2. DATE AND HOUR OF DEATH
4/27/67 1:35 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
FRANKLIN SQUARE HOSP. | | A. STATE MARYLAND
B. COUNTY Baltimore | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE 53-00 | | | |
| | | D. STREET ADDRESS (If rural, give location)
3210 ROSLIE RD. LANSDOWNE | | | |
| 5. SEX
M | 6. RACE
W | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH
2/10/1900 | 9. AGE (In years last birthday)
67 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
RETIRED | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | |
| 13. FATHER'S NAME
Carl Liebeck | | 14. MOTHER'S MAIDEN NAME
Marie Lemmert | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
YES U. S. Army | | 16. SOCIAL SECURITY NO.
213-10-2619A | | 17. INFORMANT
CATHERINE LIEBECK | |
| | | | | ADDRESS
SAME | |
| 18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
CA, LUNGS WITH GENERALIZED METASTASIS | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) DUE TO | | | |
| | | (B) DUE TO | | | |
| | | (C) | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 4/24/67 19 to 4/27 1967, that (I) (we) last saw the deceased alive on 4/27 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Incaligo | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
4/27/67 | |
| 23C. PHYSICIAN'S NAME (Type)
MILAGROSA R. CALIZO | | 23D. ADDRESS
FRANKLIN SQUARE HOSP. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
5/1/67 | | 24C. NAME of CEMETERY or CREMATORY
Baltimore National Cemetery | |
| | | | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 1 1967 | | 25B. NAME OF REGISTRAR
Robert E. Jenkins | | 25C. FUNERAL DIRECTOR
Howard H. Hubbard | |
| | | | | ADDRESS
4107 Wilkens Ave. 21229 | |

FRANKLIN SQUARE REF.

M 10

FRANKLIN

1000

912

FRANKLIN

AND BROWN

APR 10 1912

FRANKLIN

1000

FRANKLIN

CA. 1000

FRANKLIN

4/12

4/10/12

4/12

FRANKLIN

FRANKLIN

4/10/12

FRANKLIN

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | Registered No. | |
|---|---------------------|--|--|---|--|--|--|--|--|---|--|
| CERTIFICATE OF DEATH | | | | | | | | | | 67 4225 | |
| BIRTH NO.
67 4225 | | M.E. CASE NO. | | | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print)
Willia Leonard Albright | | | | | | 2. DATE AND HOUR OF DEATH
April 27, 1967 9:45 P.M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
US Public Health Service Hospital
Wyman Pk. Drive & 31st Street | | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Pa.
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Hanover
D. STREET ADDRESS (If rural, give location)
970 Baltimore Street | | | | | |
| 5. SEX
M | 6. RACE
W | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married | | 8. DATE OF BIRTH
11/6/05 | 9. AGE (In years last birthday)
61 | If Under 1 Yr. Months: Days: Hours: Min. | | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Laborer | | | | 10B. KIND OF BUSINESS OR INDUSTRY
Shoe factory | | 11. BIRTHPLACE (State or foreign country)
Pa. | | 12. CITIZEN OF WHAT COUNTRY?
USA | | | |
| 13. FATHER'S NAME
Alvin Albright | | | | | | 14. MOTHER'S MAIDEN NAME
Annie Bortner | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | | 16. SOCIAL SECURITY NO.
176-25-3037 | | 17. INFORMANT ADDRESS
Records- US PHS Hospital, Balto, Md. | | | | | |
| 18. 203X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Respiratory arrest
(A) DUE TO

ANTECEDENT CAUSES
(B) DUE TO

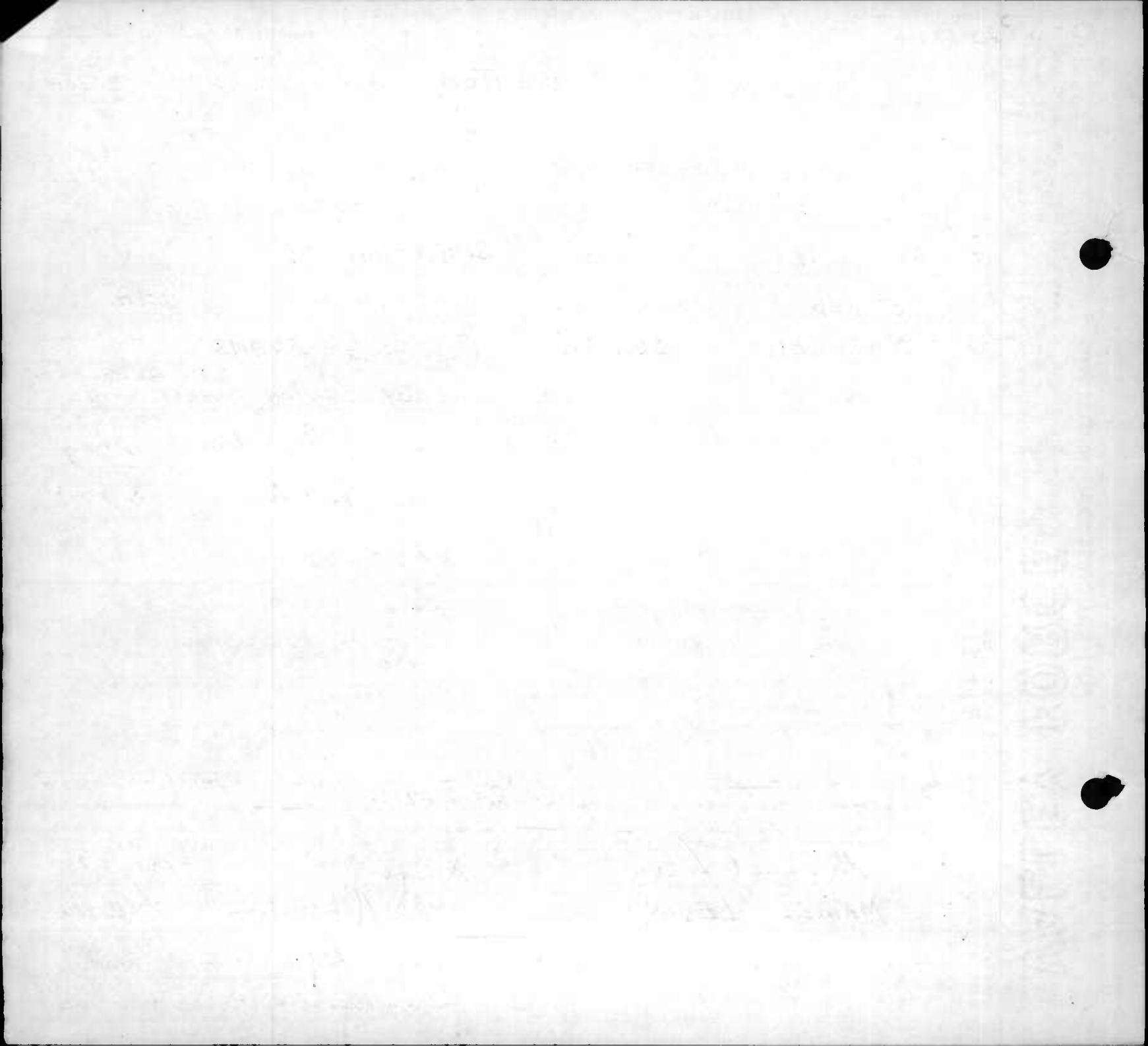
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Multiple myeloma with renal insufficiency | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
Terminal | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
no | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (1) (this hospital) attended the deceased from Apr. 2 19 67 to Apr. 27 19 67 , that (1) (we) last saw the deceased alive on Apr. 27 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE
<i>Lewis M. Slater</i>
Lewis M. Slater, Surgeon (R) | | | | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
4/28/67 | |
| 23C. PHYSICIAN'S NAME (Type)
Lewis M. Slater, Surgeon (R) | | | | 23D. ADDRESS
M.D.
Tipton - Eline Funeral Home Hampstead, Md. | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
5/1/1967 | | 24C. NAME OF CEMETERY OR CREMATORY
Penn Memorial Cemetery | | 24D. LOCATION (City, town, or county) (State)
Hanover, York Co. Pa. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 1 1967 | | | | 25B. NAME OF REGISTRAR
<i>Robert E. Tappan</i> | | 25C. FUNERAL DIRECTOR ADDRESS
Tipton - Eline Funeral Home Hampstead, Md. | | | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|----------------------|--|--|--|---|--|--|--|--|
| BIRTH NO. 67 4226 | | | | | CERTIFICATE OF DEATH | | | | |
| M.E. CASE NO. | | | | | Registered No. 67 4226 | | | | |
| 1. NAME OF DECEASED
(Type or Print) WARREN BENTON | | | | | 2. DATE AND HOUR OF DEATH
APRIL 25 1967 3:30 P.M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD. B. COUNTY BALTO. CITY | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
3720 BEEHLER AVE
00 BALTO. - MD. | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE 27-18 | | | | |
| D. STREET ADDRESS (If rural, give location)
3720 BEEHLER AVE. | | | | | | | | | |
| 5. SEX
M | 6. RACE
W. | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
MARRIED | 8. DATE OF BIRTH
SEPT. 6 - 1888 | 9. AGE (In years last birthday)
78 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
RETIRED | | | 10B. KIND OF BUSINESS OR INDUSTRY
BLDG & CONSTRUCTION | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | |
| 13. FATHER'S NAME
SAMUEL BENTON | | | 14. MOTHER'S MAIDEN NAME
JOSEPHINE EVANS | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | | 16. SOCIAL SECURITY NO.
UNKNOWN | | 17. INFORMANT
MRS LUCY BENTON ADDRESS 3720 BEEHLER AVE BALTO. - MD. | | | | |
| 18. 420.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)
Acute myocardial Infarction
CAUSE OF DEATH
(A) DUE TO
Arteriosclerotic Heart Disease
INTERVAL BETWEEN ONSET AND DEATH
1 day
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
5 years
(B) DUE TO
None
(C) DUE TO
None | | | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
None | | | | | | | | | |
| 19A. DATE OF OPERATION
0 | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No)
no | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Sept 4 1962 to April 25 1967 , that (I) we last saw the deceased alive on April 25 19 67 and that in my our opinion death occurred on the date and hour and from the causes stated above. (I) we (did) not view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
Manuel Levin | | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
4/25/67 | | |
| 23C. PHYSICIAN'S NAME (Type)
MANUEL LEVIN | | | | | 23D. ADDRESS
4818 Reisterstown Rd Baltimore | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | | 24B. DATE
4-28-67 | | 24C. NAME OF CEMETERY
ST. JOHN'S CEMETERY | | 24D. LOCATION (City, town, or county) (State)
DEAL ISLAND - MARYLAND | | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 1 1967 | | | 25B. NAME OF REGISTRAR
Robert E. Taylor | | | 25C. FUNERAL DIRECTOR
Leroy Webster - PRINCESS ANNE MD. ADDRESS 21853 | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|--------------|---|------------------------------|---|---|
| BIRTH NO. 67 4227 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 4227 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) HUNT, MAMIE S. | | 2. DATE AND HOUR OF DEATH
4/26/67 6:30 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD. B. COUNTY BALTIMORE | | 5. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE | |
| FULL NAME OF HOSPITAL OR INSTITUTION
42 SINAI HOSPITAL | | D. STREET ADDRESS (If rural, give location)
3534 HICKORY AVE. #11 | | 13-06 | |
| 5. SEX
F | 6. RACE
W | 7. MARRIED, NEVER MARRIED
WIDOWED | 8. DATE OF BIRTH
12/25/92 | 9. AGE (In years last birthday)
74 | 10. If Under 1 Yr. Months Days Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY
? | | 11. BIRTHPLACE (State or foreign country)
MD. | |
| 12. CITIZEN OF WHAT COUNTRY?
? U.S.A. | | 13. FATHER'S NAME
? | | 14. MOTHER'S MAIDEN NAME
? | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
217-09-7405 | | 17. INFORMANT
W. HUNT | |
| 18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | INTERVAL BETWEEN ONSET AND DEATH
6 days
20 yrs.
— | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from 4/20/67 to 4/26/67, that (I) (we) last saw the deceased alive on 4/26/67 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE
Hyman Greenfield | | 23B. DATE SIGNED
4/26/67 | | 23C. PHYSICIAN'S NAME (Type)
HYMAN GREENFIELD M.D. | |
| 23D. ADDRESS
SINAI HOSPITAL | | 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
4/29/67 | |
| 24C. NAME OF CEMETERY or CREMATORY
MT. ZION | | 24D. LOCATION (City, town, or county) (State)
BALTO. CO. | | 25A. DATE REC'D BY HEALTH DEPT.
MAY 1 1967 | |
| 25B. NAME OF REGISTRAR
R. E. Taylor | | 25C. FUNERAL DIRECTOR
R. E. Taylor | | 25D. ADDRESS
3600 Chestnut Ave. | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | | | Registered No. <u>15-7797228</u> | |
|---|-------------------|---|--|--|--|
| BIRTH NO. <u>67 4228</u> | | | | | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED
(Type or Print) <u>Bertram E. Mooney</u> | | 2. DATE AND HOUR OF DEATH
<u>April 28th 1967</u> <u>8²⁰</u> <u>A</u> M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>35 Church Home and Hospital</u> | | A. STATE <u>Maryland</u> B. COUNTY <u>Bel Air</u> C. CITY OR TOWN <u>Harford Co.</u>
(If outside city limits, write RURAL and give township) <u>62-32</u> | | | |
| D. STREET ADDRESS (If rural, give location)
<u>312 Linwood Ave.</u> | | | | | |
| 5. SEX <u>M.</u> | 6. RACE <u>W.</u> | 7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED
<input type="checkbox"/> WIDOWED, <input type="checkbox"/> DIVORCED (specify) | 8. DATE OF BIRTH
<u>Jan 6th 1906</u> | 9. AGE (In years lost birthday)
<u>61</u> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Accountant</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>Better Kds Corp.</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Baltimore Md.</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>American</u> | | | | | |
| 13. FATHER'S NAME
<u>Samuel P. Mooney</u> | | | 14. MOTHER'S MAIDEN NAME
<u>Sarah A. Murray</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
<u>220-14-8517</u> | | 17. INFORMANT
<u>Mooney, Mr. Bertram</u> ADDRESS <u>312 Linwood Ave. Bel Air, Md.</u> | |
| 18. <u>5-22-11-002.1</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) DUE TO <u>Cardio - Pulmonary Shock</u>
(B) DUE TO <u>Hepatic Failure</u>
(C) <u>Acute and chronic diverticulitis of colon with vesico-intestinal fistula</u>
<u>Pulmonary TB</u> | | | |
| MEDICAL CERTIFICATION | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
<u>4-24-67</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
<u>Diverticulosis</u> | | 20A. AUTOPSY? (Yes or No)
<u>No</u> | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> (Specify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While <input checked="" type="checkbox"/> At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that the (this hospital) attended the deceased from <u>April 18th</u> 19 <u>67</u> to <u>April 28th</u> 19 <u>67</u> , that it (we) last saw the deceased alive on <u>April 28th</u> 19 <u>67</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. It (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>asstunk</u> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
<u>4-28-67</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>Dr. Howard Rosin</u> | | 23D. ADDRESS
<u>CH & IF</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>5/1/67</u> | | 24C. NAME OF CEMETERY OR CREMATORY
<u>Loudon Park Cemetery</u> | |
| 24D. LOCATION (City, town, or county) (State)
<u>Baltimore, Md.</u> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>MAY 1 1967</u> | | 25B. NAME OF REGISTRAR
<u>Reg. Sec. J. J. ...</u> | | 25C. FUNERAL DIRECTOR
<u>Schimunek Funeral Home, Inc.</u>
<u>3331 Brehms Lane</u> | |

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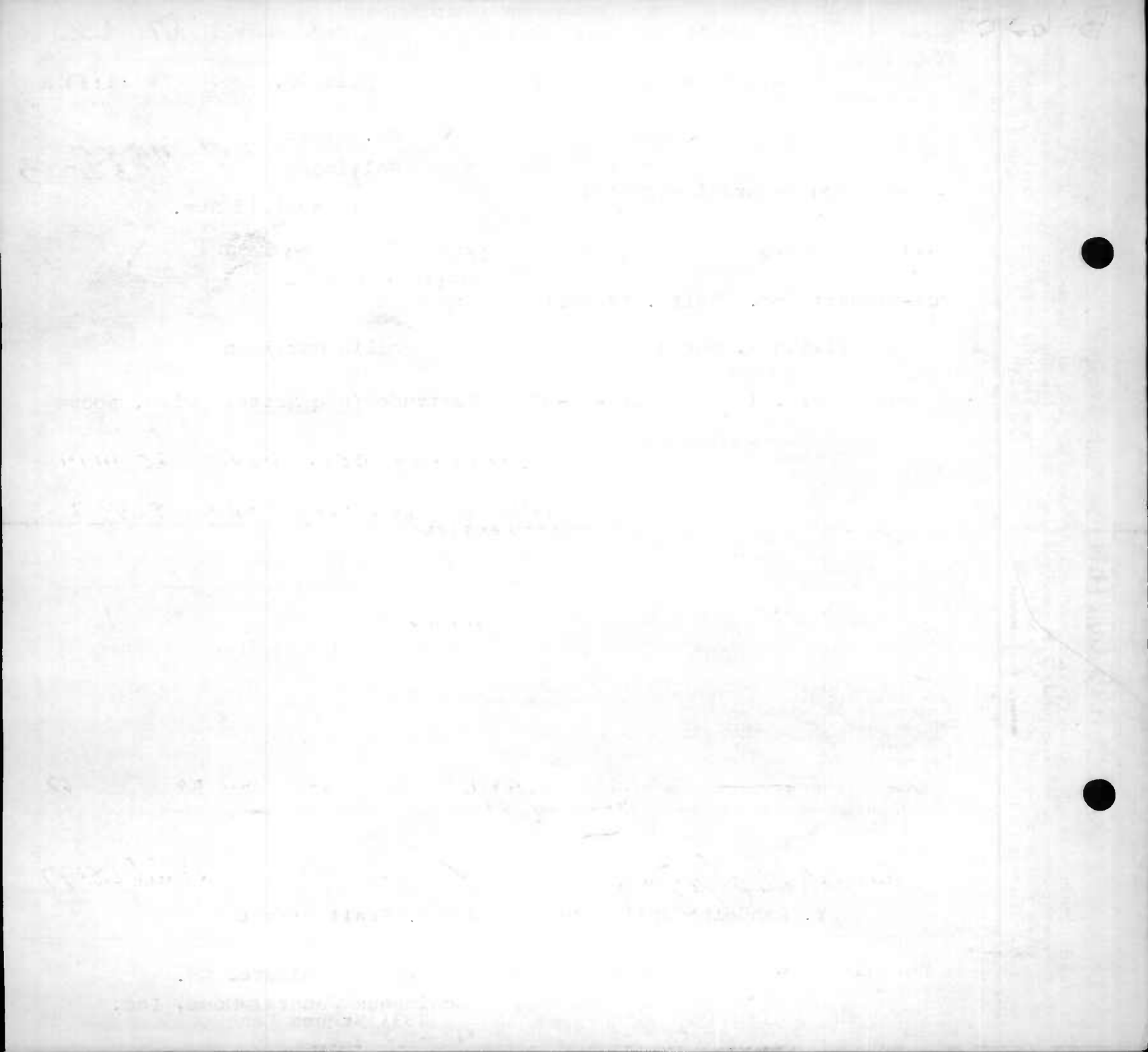
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | | | | |
|--|--|------------------|--|---|---|------------------------------|--|---------------------------------------|--|--|--|-----------------------------|--|--|
| 67 4229 | | | | | CERTIFICATE OF DEATH | | | | | Registered No. 67 4229 | | | | |
| BIRTH NO. | | | | | M.E. CASE NO. | | | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) | | | | | OLIVER HARRISON BURCH | | | | | 2. DATE AND HOUR OF DEATH
April 26, 1967 11:30 a.m. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
Md. 21213 | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location)
44 Union Memorial Hospital | | | | | | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | | | | |
| | | | | | | | | | | D. STREET ADDRESS (If rural, give location)
3047 Mayfield Ave. | | | | |
| 5. SEX
male | | 6. RACE
white | | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
married | | 8. DATE OF BIRTH
1/1/1887 | | 9. AGE (In years last birthday)
80 | | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
ret-Transit Opr. | | | | | 10B. KIND OF BUSINESS OR INDUSTRY
Balto. Transit | | | | | 11. BIRTHPLACE (State or foreign country)
Huntington Maryland | | | | |
| 12. CITIZEN OF WHAT COUNTRY? | | | | | 13. FATHER'S NAME
William R. Burch | | | | | 14. MOTHER'S MAIDEN NAME
Sallie Harrison | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
yes W.W. 1 | | | | | 16. SOCIAL SECURITY NO.
215-09-3700 | | | | | 17. INFORMANT ADDRESS
Gertbude (nee Meisel) wife, above | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)
420.11 | | | | | | | | | | CAUSE OF DEATH
(A) CORONARY OCCLUSION 20 m 14
(B) ARTERIOSCLEROTIC HEART & HYPER TENSION 5 y 7
(C) | | | | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
none | | | | | | | | | | | | | | |
| 19A. DATE OF OPERATION | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20A. AUTOPSY? (Yes or No) | | | | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | |
| 21F. HOW DID INJURY OCCUR? | | | | | 22. I certify that (I) (the hospital) attended the deceased from Feb 1, 1963 to Mar 29, 1967, that (I) (we) last saw the deceased alive on MAR 29, 67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
Randolph H. Spitzberg | | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | | | 23B. DATE SIGNED
April 28, 67 | | | | |
| 23C. PHYSICIAN'S NAME (Type)
Dr. Randolph Spitzberg | | | | | M.D. 23D. ADDRESS
338 W. Pratt Street | | | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | | | | 24B. DATE
4/29/67 | | | | | 24C. NAME of CEMETERY or CREMATORY
Holy Redeemer Cemetery | | | | |
| 24D. LOCATION (City, town, or county) (State)
Baltimore, Md. | | | | | 25A. DATE REC'D BY HEALTH DEPT.
MAY 1 1967 | | | | | 25B. NAME OF REGISTRAR
Robert E. Finkbeiner | | | | |
| 25C. FUNERAL DIRECTOR ADDRESS
Schimunek Funeral Home, Inc.
3331 Brehms Lane | | | | | | | | | | | | | | |



Released on approval of Medical Examiner.
FURNAL DIRECTOR: IMPORTANT

67 4230

CERTIFICATE OF DEATH

Registered No. 67 4230

BIRTH NO. 67 4230

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) LUT2 FRANK W alter

2. DATE AND HOUR OF DEATH April 29 1967 1:50 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) CHURCH HOME * HOSPITAL BALTIMORE MARYLAND

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY

5. SEX MALE 6. RACE WHITE 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED

8. DATE OF BIRTH 10/15/05 9. AGE (In years last birthday) 61 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Elect. WELDER 11. BIRTHPLACE (State or foreign country) MARYLAND 12. CITIZEN OF WHAT COUNTRY? AMERICAN

13. FATHER'S NAME WALTER LUT2 14. MOTHER'S MAIDEN NAME UNKNOWN Amelia Kapatian

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No 16. SOCIAL SECURITY NO. 215-09-9975 17. INFORMANT ADDRESS Mrs. Rena M. Lutz 33 S. East Avenue

18. 5020 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH RESPIRATORY failure 2 weeks

19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (B) DUE TO Recurrent pneumonia. Emphysema (C) DUE TO Chronic Bronchitis. Coronary artery disease

20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

21. MEDICAL CERTIFICATION 22. I certify that (I) (this hospital) attended the deceased from 2/26/67 to 4/29 1967, that (I) (we) lost saw the deceased alive on 4/29 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

23. SIGNATURE Joe Martinez M.D. 24. DATE SIGNED 4/29/67

25. PHYSICIAN'S NAME (Type) Jose MARTINEZ M.D. 26. ADDRESS 100 N. Broadway 21231

27. BURIAL CREMATION, REMOVAL (Specify) Burial 28. DATE 5/3/1967 29. NAME OF CEMETERY or CREMATORY Bohemian National Cemetery 30. LOCATION Baltimore, Maryland

31. DATE REC'D BY HEALTH DEPT. MAY 1 1967 32. NAME OF REGISTRAR Robert E. Farlow 33. FUNERAL DIRECTOR John A. Marap Inc. 3000 E. Baltimore St.

3:32 AM 37:40 3:48 PM

24 38 J 24J 45.33

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>67 4231</u> | |
|--|---|---|--|---|--|
| BIRTH NO. <u>67 4231</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) <u>EMMA F. ROBERTS</u> | | 2. DATE AND HOUR OF DEATH
<u>4-28-67</u> <u>9:20 A.M.</u> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE <u>MD.</u> B. COUNTY <u>BALTIMORE</u> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>BALTIMORE, MD.</u> <u>21223</u> | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<u>U. OF MD. HOSPITAL</u> | | D. STREET ADDRESS (If rural, give location)
<u>2842 W. MULBERRY ST</u> | | | |
| 5. SEX
<u>F</u> | 6. RACE
<u>C</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
<u>MARRIED</u> | 8. DATE OF BIRTH
<u>2-10-16</u> | 9. AGE (In years lost birthday)
<u>51</u> | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>HOUSEWIFE</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>—</u> | | 11. BIRTHPLACE (State or foreign country)
<u>USA MD.</u> | |
| 13. FATHER'S NAME
<u>HARVEY PITTS</u> | | 14. MOTHER'S MAIDEN NAME
<u>ESTELLE SHERWOOD (DEC.)</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>NO</u> | | 16. SOCIAL SECURITY NO.
<u>—</u> | | 17. INFORMANT
<u>HUSBAND</u> | |
| | | | | ADDRESS
<u>SAME</u> | |
| 18. <u>I</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
<u>BILATERAL CARCINOMA (ADENO) OF THE BREAST & NODE CHEST & BONE METASTASIS</u> | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH
<u>3 YEARS</u> | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) DUE TO
(B) DUE TO
(C) DUE TO | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19. DATE OF OPERATION
<u>2-10-66</u> | | 20. AUTOPSY? (Yes or No)
<u>NO</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<u>NO</u> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
<u>—</u> | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
<u>—</u> | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)
<u>—</u> | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR?
<u>—</u> | |
| 22. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>JULY 1964</u> to <u>April 28, 1967</u> . that (I) <u>(we)</u> last saw the deceased alive on <u>April 28, 1967</u> and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(we)</u> (did) <u>(did not)</u> view the body after death. | | | | | |
| 23A. SIGNATURE
<u>Charles S. Harrison</u> M.D. | | | | 23B. DATE SIGNED
<u>4-28-67</u> | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS
M.D. <u>U. OF MD. HOSPITAL BALTO, MD.</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | 24B. DATE
<u>5-2-67</u> | 24C. NAME OF CEMETERY or CREMATORY
<u>Carver Memorial Park</u> | 24D. LOCATION (City, town, or county) (State)
<u>Laurel, Md</u> | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>MAY 1 1967</u> | 25B. NAME OF REGISTRAR
<u>Charles E. Feltman</u> | 25C. FUNERAL DIRECTOR
<u>Charles E. Feltman</u> | ADDRESS
<u>6614 Barney</u> | | |

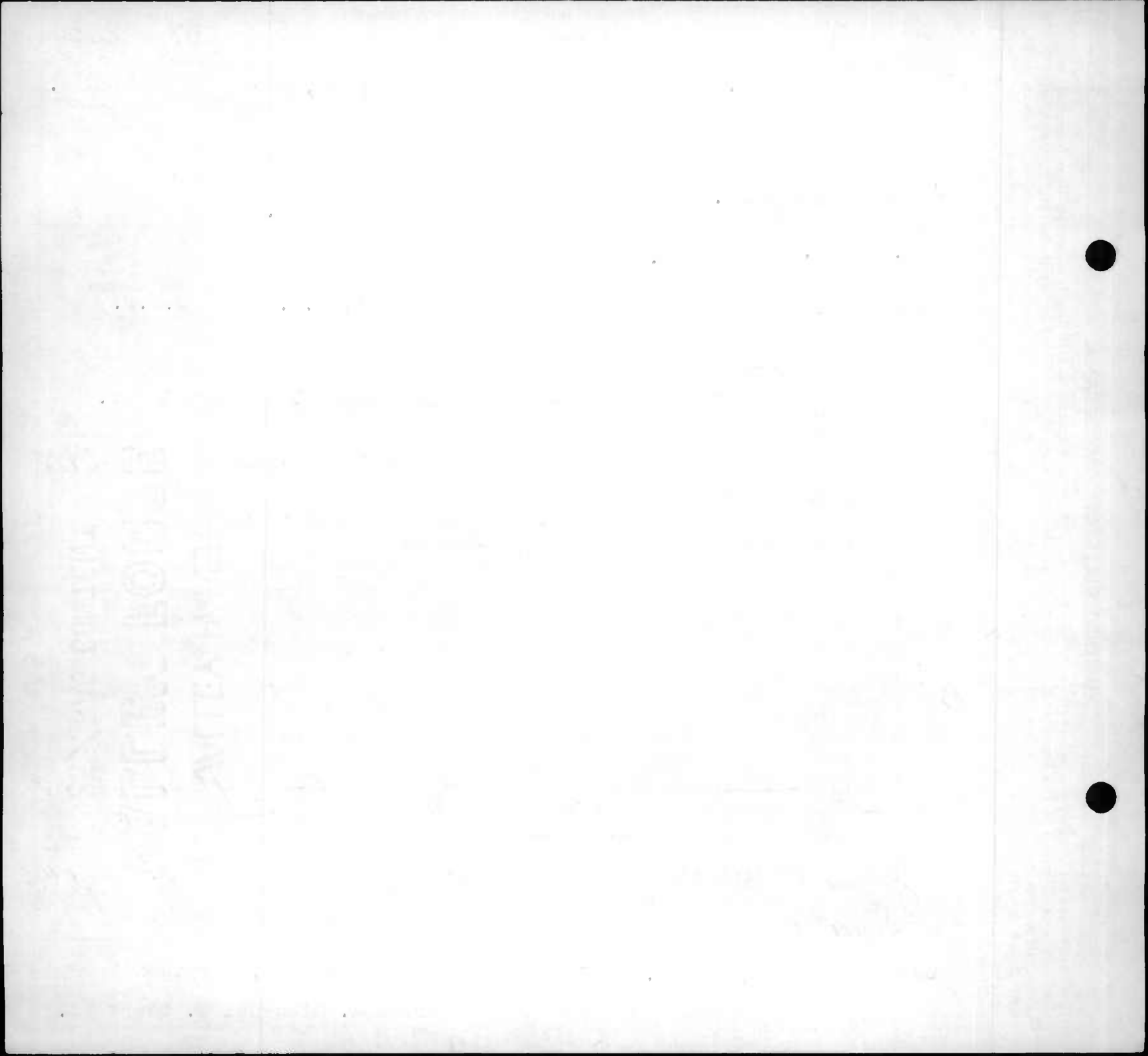
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 4232 | |
|---|---------------|--|---|--|---|
| BIRTH NO. 67 4232 | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | MARY A. BUNDY | | May 29, 1967 7:30 A. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION

1348 Carroll St. | | | A. STATE
Maryland
B. COUNTY
Baltimore | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | D. STREET ADDRESS (If rural, give location) | | |
| | | | 1348 Carroll St. | | |
| 5. SEX
F. | 6. RACE
C. | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
M. | 8. DATE OF BIRTH
5/2/99 | 9. AGE (In years last birthday)
67 | 10. Under 1 Yr. Months Days
Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Washington, D.C. | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
Unknown | | 14. MOTHER'S MAIDEN NAME
Unknown | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
213-05-8992 | | 17. INFORMANT ADDRESS
Walter Bundy 1348 Carroll St. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH
(A) Myocardial Infarction
DUE TO
(B) Hypertensive Cardiovascular Disease
DUE TO
(C) | | INTERVAL BETWEEN ONSET AND DEATH
Sudden
15 years |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 4/6/67 to 4/29/67, that (I) (we) last saw the deceased alive on 4/29/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
John P. Urlock Jr. | | | | 23B. DATE SIGNED
May 1, 1967 | |
| 23C. PHYSICIAN'S NAME (Type)
JOHN P. URLOCK JR. | | 23D. ADDRESS
1227 Washington Blvd | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
5/3/67 | | 24C. NAME OF CEMETERY or CREMATORY
Mt. Zion | |
| 24D. LOCATION (City, town, or county) (State)
Lansdown, Maryland | | 25A. DATE REC'D BY HEALTH DEPT.
MAY 1 1967 | | | |
| 25B. NAME OF REGISTRAR
Robert E. Johnson | | 25C. FUNERAL DIRECTOR ADDRESS
Charles A. Rice 661 W. Barre St. | | | |



Released Nov 22 Med by Dr. Hirsch, M.D.
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 4233 | |
|--|---------------------|---|--|--|---|
| BIRTH NO. 67 4233 | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED
(Type or Print) LEE, DELORES VERA | | | 2. DATE AND HOUR OF DEATH
1A 4/30/67 | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF INSTITUTION (If not in hospital or institution, give street address or location)
33 Mrs Hopkins Hospital | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE Maryland B. COUNTY 22-01
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
131 W Hill St | | |
| 5. SEX
F | 6. RACE
C | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH
9-5-30 | 9. AGE (In years last birthday)
36 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country)
Baltimore Md. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. |
| 13. FATHER'S NAME
John Keenan | | | 14. MOTHER'S MAIDEN NAME
CHRISTINE DAVIS | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
? | 17. INFORMANT
EMERGENCY RD SHOOT | | |
| 18. 445X1
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
Malignant hypertension
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.
CVA. | | | CAUSE OF DEATH
INTERVAL BETWEEN ONSET AND DEATH
year | | |
| MEDICAL CERTIFICATION
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
VED | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 4/30 1967 to 4/30 1967 , that (I) (we) last saw the deceased alive on 4/30 1967 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
John Hsing Hsu | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED |
| 23C. PHYSICIAN'S NAME (Type)
TAH-Hsing Hsu | | | 23D. ADDRESS
The Johns Hopkins Hospital | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
5/4/67 | | 24C. NAME of CEMETERY or CREMATORY
Mt Auburn | |
| 24D. LOCATION (City, town, or county) (State)
Baltimore Md | | 25A. DATE REC'D BY HEALTH DEPT.
MAY 1 1967 | | | |
| 25B. NAME OF REGISTRAR
Robert E. Taylor | | 25C. FUNERAL DIRECTOR
Charles A Rice 661 W Barrett | | | |

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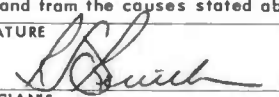
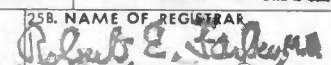
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 4234 | |
|--|-------------------------|---|---|--|---|
| CERTIFICATE OF DEATH | | | | | |
| 1. NAME OF DECEASED
(Type or Print) MALLALIEU, CARROLL V. | | 2. DATE AND HOUR OF DEATH
APRIL 28, 1967 5:25 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
ST. AGNES HOSPITAL
CATON & WILKENS AVES.
BALTO., MD. 21229 | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND 21223
C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE
D. STREET ADDRESS (If rural, give location) 2719 WILKENS AVENUE | | | |
| 5. SEX
MALE | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
WIDOWED | 8. DATE OF BIRTH
5-27-90 | 9. AGE (In years last birthday)
76 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
RETIRED Wire Chief | | 10B. KIND OF BUSINESS OR INDUSTRY
C & P Telephone Co. UNKNOWN | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | |
| 13. FATHER'S NAME
W. FRANK MALLALIEU | | | 12. CITIZEN OF WHAT COUNTRY?
U S A | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
UNKNOWN NO | | | 16. SOCIAL SECURITY NO.
212 10 0622 | | |
| 17. INFORMANT
CATON & WILKENS AVES. #212298 | | | ADDRESS
HOSPITAL RECORDS-ST. AGNES HOSPITAL | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)
RUPTURED ABDOMINAL ANEURYSM | | CAUSE OF DEATH
ARTERIO-SCLEROTIC CARDIO-VASCULAR DISEASE | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (X) (this hospital) attended the deceased from APRIL 19, 1967 to APRIL 28, 1967 , that (X) (we) last saw the deceased alive on APRIL 28, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
 | | | | 23B. DATE SIGNED
04/28/67 | |
| 23C. PHYSICIAN'S NAME (Type)
R M REVILLA, MD. | | | | 23D. ADDRESS
BALTO., MD 21229
ST. AGNES HOSPITAL-CATON & WILKENS AVES. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
5-2-67 | | 24C. NAME of CEMETERY or CREMATORY
New Cathedral Cem. | |
| 24D. LOCATION
Balto., Md. | | 25A. DATE REC'D BY HEALTH DEPT.
MAY 1 1967 | | | |
| 25B. NAME OF REGISTRAR
 | | 25C. FUNERAL DIRECTOR
Witzke F. D. - 4101 Edmondson Ave. | | | |

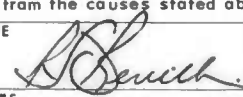
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|------------------|--|---|--|--|--|--|-----------------------------|--|
| 67 4235 | | | | | Registered No. 67 4235 | | | | |
| BIRTH NO. | | | | | M.E. CASE NO. | | | | |
| 1. NAME OF DECEASED
(Type or Print) | | | | | 2. DATE AND HOUR OF DEATH | | | | |
| SEITLER, HARRY E. | | | | | APRIL 27, 1967 1:50P M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location)

40 ST. AGNES HOSPITAL | | | | | A. STATE
MARYLAND | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location)
21-02
1178 WASHINGTON BLVD 21230 | | | | |
| | | | | | | | | | |
| 5. SEX
MALE | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
SEPARATED Divorced | | 8. DATE OF BIRTH
4/11/86 | 9. AGE (In years last birthday)
81 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
RETIRED | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
BALTIMORE, MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | |
| 13. FATHER'S NAME
CHARLES | | | | | 14. MOTHER'S MAIDEN NAME
LOUISA C. BROWN | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NONE NONE | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
Mrs. Grace S. Garrity-1123 Courtney Rd.
ST. AGNES HOSPITAL RECORDS | | | | |
| 18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | INTERVAL BETWEEN ONSET AND DEATH
2-3 WEEKS | | | | |
| | | | | | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from MARCH 28 19 67 to APRIL 27 19 67, that (I) (we) last saw the deceased alive on APRIL 27 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
 | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | 23B. DATE SIGNED
4-27-67 | |
| 23C. PHYSICIAN'S NAME (Type)
R. REVILLA | | | | | 23D. ADDRESS
M.D. ST AGNES HOSP. CATON & WILKENS AVES. 21229 | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
5-1-67 | | 24C. NAME OF CEMETERY or CREMATORY
Western Cem. | | 24D. LOCATION (City, town, or county) (State)
Balto., Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 1 1967 | | | 25B. NAME OF REGISTRAR
D. B. E. Johnson | | 25C. FUNERAL DIRECTOR ADDRESS
Witzke F. D. - 4101 Edmondson Ave. | | | | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|---------------------|---|---|---|--|---|--|------------------------------------|--|
| CERTIFICATE OF DEATH | | | | | Registered No. 67 4236 | | | | |
| BIRTH NO. 263 67 4236 | | M.E. CASE NO. | | | 2. DATE AND HOUR OF DEATH
April 28, 1967 | | | | |
| 1. NAME OF DECEASED
(Type or Print) Louise Dukehart | | | | | M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
00 4901 Alson Drive | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location)
4901 Alson Drive | | | | |
| 5. SEX
F | 6. RACE
W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
Never Married | | 8. DATE OF BIRTH
July 21 1887 | 9. AGE (In years last birthday)
79 | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired | | | 10B. KIND OF BUSINESS OR INDUSTRY
Practical Nurse | | 11. BIRTHPLACE (State or foreign country)
Penna | | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME
Adam J Dukehart | | | | | 14. MOTHER'S MAIDEN NAME
Anna | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO.
218-32-2756 | | 17. INFORMANT ADDRESS
Edward Dukehart 815 Seminary Ave 21093 | | | | |
| 18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)
4201 I
Acute myocardial infarction
INTERVAL BETWEEN ONSET AND DEATH
5 minutes
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Arteriosclerotic cardiovascular disease
Several years | | | | | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 19 57 to April 28, 1967, that (I) last saw the deceased alive on April 18, 1967 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
Seymour H. Rubin | | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | 23B. DATE SIGNED
4/29/67 | |
| 25C. PHYSICIAN'S NAME (Type)
Seymour H. Rubin | | | | | 23D. ADDRESS
5415 Park Heights Ave. | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
May 1 '67 | | 24C. NAME OF CEMETERY or CREMATORY
St. Andrew | | 24D. LOCATION (City, town, or county) (State)
Waynesboro Franklin Co. Penna | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 1 1967 | | | 25B. NAME OF REGISTRAR
Philip E. Fagley | | | 25C. FUNERAL DIRECTOR ADDRESS
Witzke 4101 Edmondson Ave Balto. Md. | | | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 4237 | |
|---|---------------------|--|---|--|--|
| CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. 67 4237 | | | | | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED
(Type or Print) SNOUFFER, EVELYN SPENCER | | | 2. DATE AND HOUR OF DEATH
29 APRIL 67 3:58 PM | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
UNION MEMORIAL HOSP. | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD. B. COUNTY BALTIMORE
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE
D. STREET ADDRESS (If rural, give location)
5104 GREENWICH AVE. | | |
| 5. SEX
F | 6. RACE
W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
WIDOWED | 8. DATE OF BIRTH
12-28-98 | 9. AGE (In years last birthday)
68 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
RETIRED | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Maryland |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | | | | |
| 13. FATHER'S NAME
WILLIAM T. SPENCER | | | 14. MOTHER'S MAIDEN NAME
URSULA SCHULZ | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO.
219-28-2525 | | 17. INFORMANT
Rev. Philip T. Snouffer
1415 N. Caroline St. - 21223 |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Cerebral Hemorrhage | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
HASBOND | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (H) (this hospital) attended the deceased from 29 APRIL 1967 to 29 APRIL 1967 , that (H) (we) last saw the deceased alive on 29 APRIL 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Sidney E. Kirkley | | | | 23B. DATE SIGNED
29 APRIL 67 | |
| 23C. PHYSICIAN'S NAME (Type)
SIDNEY E. KIRKLEY | | | | 23D. ADDRESS
THE UNION MEMORIAL HOSPITAL | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
5-2-67 | | 24C. NAME OF CEMETERY or CREMATORY
New Cathedral Cem. | |
| 24D. LOCATION (City, town, or county) (State)
Baltimore, Md. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR
Witzke F. D. | | 25C. FUNERAL DIRECTOR
Witzke F. D. - 4101 Edmondson Ave. | |

Union Memorial Hall

F W 12-28-98

GETTING

William T. Spencer

ST. LOUIS

US 12-28-98
Rev. Philip J. Spencer
1212 N. Caroline St. - ST. LOUIS

Richard L. Kuty

THE UNION MEMORIAL HALL

St. Louis, Mo.
12-28-98
1212 N. Caroline St.
St. Louis, Mo.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Certificate of Death | | Registered No. 67 4238 | |
|--|---------------------|--|--|---|--|--|--|
| BIRTH NO. 67 4238 | | M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) MANNERS HELEN Alverta | | 2. DATE AND HOUR OF DEATH
4/29/67 9-30 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
LUTHERAN HOSPITAL OF MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE
D. STREET ADDRESS (If rural, give location)
4910 Challedon Rd. - Wakefield | | | |
| 5. SEX
F | 6. RACE
W | 7. PREVIOUSLY EVER MARRIED
WIDOWED, DIVORCED (Specify)
MARRIED Divorced | | 8. DATE OF BIRTH
3-25-18 | 9. AGE (In years last birthday)
48 | 10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Clerical | | 10B. KIND OF BUSINESS OR INDUSTRY
Jenkins Jewelers | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Late - Carroll J. Airey | | | | 14. MOTHER'S MAIDEN NAME
4910 Challedon Road
Helen G. Ampacher Fillings | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
214-12-4461 | | 17. INFORMANT
Mrs. Helen Fillings
Edward Manners
411 N. Bradford St. - 21224 | | | |
| 18. 4-20-1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
Crown artery sclerosis. | | | | CAUSE OF DEATH
(A) DUE TO
(B) DUE TO
(C) DUE TO | | | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| II | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) <u>this hospital</u> attended the deceased from 3-16-1967 to 4-29-1967 , that (I) <u>we</u> last saw the deceased alive on 4/29/1967 and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>We</u> <u>did</u> (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
V. Biswanath Pillai | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type)
V. BISWANATH PILLAI M.D. | | | | 23D. ADDRESS
730 ASHBURTON STREET | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
5-4-67 | | 24C. NAME OF CEMETERY or CREMATORY
New Freedom Cem. | | 24D. LOCATION (City, town, or county) (State)
New Freedom, Pa. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR
MAY 1 1967 Robert E. Johnson | | 25C. FUNERAL DIRECTOR
Witzke F. D. | | ADDRESS
4101 Edmondson Ave. | |

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 4239 | |
|--|-------------------------|---|------------------------------------|---|---|
| BIRTH NO. 67 4239 | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) <u>LAWSON ISAAC C. Earl</u> | | 2. DATE AND HOUR OF DEATH
<u>4-26-67</u> <u>9:15 P.M.</u> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE <u>MD</u>
B. COUNTY <u>BALTIMORE</u> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>BALTIMORE</u> | |
| FULL NAME OF INSTITUTION (If not in hospital or institution, give street address or location)
<u>BALTIMORE CITY HOSP</u>
<u>4940 Eastern Avenue, Baltimore, Maryland</u> | | D. STREET ADDRESS (Location)
<u>1417 MADISON AVE</u> | | <u>21224</u> | |
| 5. SEX
<u>Male</u> | 6. RACE
<u>Negro</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
<u>Married</u> | 8. DATE OF BIRTH
<u>7-16-21</u> | 9. AGE (In years last birthday)
<u>45</u> | 10. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Machine operator</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>Factory</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Virginia</u> | |
| 13. FATHER'S NAME
<u>Wm. Lawson</u> | | 14. MOTHER'S MAIDEN NAME
<u>Mathie Wade</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>213-18-0767</u> | | 17. INFORMANT
<u>Records: BCM-4940 Eastern Avenue 21224</u> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenio, etc. It means the disease, injury or complication which caused death.)
<u>Hemorrhage</u> | | CAUSE OF DEATH
(A) DUE TO
<u>Pulmonary Tuberculosis</u>
(B) DUE TO
<u>years</u>
(C) | | INTERVAL BETWEEN ONSET AND DEATH
<u>Minutes</u> | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
<u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<u>NO</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>10/17/63</u> 19 to <u>4/26/67</u> 19, that (I) (we) last saw the deceased alive on <u>4/26/67</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>Joseph I. Berman</u> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
<u>4/26/67</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>Joseph I. Berman</u> | | 23D. ADDRESS
M.D. <u>4940 Eastern Avenue, Baltimore, Maryland</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>5/1/67</u> | | 24C. NAME OF CEMETERY or CREMATORY
<u>Int. Auburn</u> | |
| 24D. LOCATION (City, town, or county) (State)
<u>Balto. Md.</u> | | 25A. DATE REC'D BY HEALTH DEPT.
<u>MAY 1, 1967</u> | | 25B. NAME OF REGISTRAR
<u>John L. Chatman</u> | |
| 25C. FUNERAL DIRECTOR
<u>John L. Chatman</u> | | ADDRESS
<u>1701 Mt. Calvert</u> | | | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|-------------------------|---|---|---|--|--|------------------------------------|---|--|
| BIRTH NO. 67 4240 | | | | | CERTIFICATE OF DEATH | | | | |
| Registered No. 67 4240 | | | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) <u>Agelopus, Stella</u> (Stella Agelopus) | | | | | 2. DATE AND HOUR OF DEATH
<u>4/29/67</u> <u>2:30 P.M.</u> | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A, STATE <u>Maryland</u> , B, COUNTY <u>Baltimore</u> | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<u>31 Baltimore City Hospitals</u>
<u>4940 Eastern Avenue</u>
<u>Baltimore, Maryland #21224</u> | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>Baltimore</u> <u>53-00</u> | | | | |
| D. STREET ADDRESS (If rural, give location)
<u>1831 Portship Road #21222</u> <u>005</u> | | | | | | | | | |
| 5. SEX
<u>Female</u> | 6. RACE
<u>Cauc.</u> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<u>Wid.</u> | 8. DATE OF BIRTH
<u>11-2-97</u> | 9. AGE (In years last birthday)
<u>69</u> | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY
— | | | 11. BIRTHPLACE (State or foreign country)
<u>Greece</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>Greece</u> | |
| 13. FATHER'S NAME
<u>John</u> | | | 14. MOTHER'S MAIDEN NAME
<u>Eugenia</u> | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>No</u> | | | 16. SOCIAL SECURITY NO.
<u>None</u> | | 17. INFORMANT ADDRESS
BC# 4940 Eastern Avenue
RECORDS: <u>Baltimore, Maryland #21224</u> | | | | |
| 18. <u>420.1 I</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | CAUSE OF DEATH
(A) <u>Acute anterior MI</u> <u>40 hr.</u>
DUE TO
(B) <u>Arteriosclerotic card-vasc dis.</u> <u>unknown</u>
DUE TO
(C) _____ | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | <u>Parkinson's Disease, old post. MI</u> <u>unknown</u> | | | | |
| 19A. DATE OF OPERATION
<u>0 none-</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
— | | 20A. AUTOPSY? (Yes or No)
<u>NO</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<u>no</u> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
— | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)
— | | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)
(APPROX.)
— | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR?
— | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>4/28/67</u> 19 <u>67</u> to <u>4/29/67</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4/29</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <u>did</u> (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
<u>W. Douglas, III</u> M.D. | | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
<u>4/29/67</u> | | |
| 23C. PHYSICIAN'S NAME (Type)
<u>SMITH W. Douglas III</u> | | | 23D. ADDRESS
M.D. <u>4940 Eastern Avenue Baltimore, Md. #21224</u> | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>5-2-67</u> | | 24C. NAME OF CEMETERY OR CREMATORY
<u>Greek Orthodox Cemetery Baltimore, Md.</u> | | 24D. LOCATION (City, town, or county) (State)
<u>Baltimore, Md.</u> | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>MAY 1 1967</u> | | 25B. NAME OF REGISTRAR
<u>Robert E. Taylor</u> | | 25C. FUNERAL DIRECTOR
<u>Nicholas T. Matthews</u>
<u>3021 Eastern Ave, Baltimore, Md.</u> | | ADDRESS | | | |

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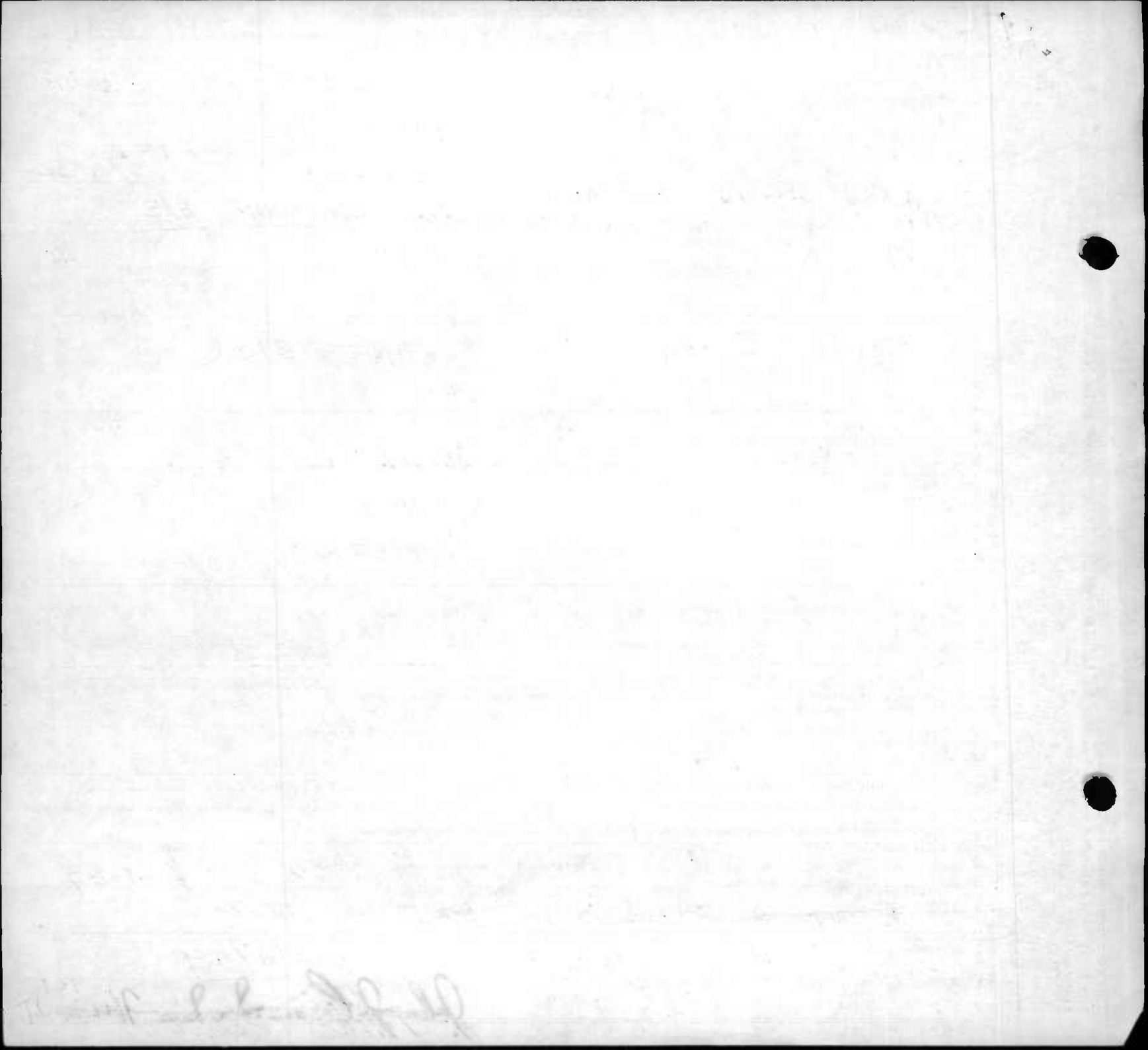
1907

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|---|------------------|--|---------------------------------|
| BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 4241 | |
| BIRTH NO. 67-67 4241
M.E. CASE NO. 67-08730 | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED
(Type or Print) Baby Bay Cager | | 2. DATE AND HOUR OF DEATH
4-27-67 10:55 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
34 BEN SECOURS HOSPITAL | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE BALTIMORE MD
B. COUNTY BALTIMORE
C. CITY OR TOWN (If outside city limits, write RURAL and give township) 20-02
D. STREET ADDRESS (If rural, give location) 2115 EDMONDSON AVE | |
| 5. SEX M | 6. RACE N | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) — | 8. DATE OF BIRTH 4-27-67 |
| 9. AGE (In years last birthday) 40 | | 10. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME EDWARD CAGER | | 14. MOTHER'S MAIDEN NAME JOYCE BLAIR | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Mother | | ADDRESS 2115 EDMONDSON AVE | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
ANOXIA
PROLAPSED CORD
PREMATURITY | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 4-27 19 67 to 4-27 19 67 , that (I) (we) last saw the deceased alive on 4-27 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE Alex A. Melocoton M.D. | | 23B. DATE SIGNED 4-27-67 | |
| 23C. PHYSICIAN'S NAME (Type) ALEX A. MELOCOTON M.D. | | 23D. ADDRESS BEN SECOURS HOSPITAL | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 4/28/67 | |
| 24C. NAME OF CEMETERY or CREMATORY ST Peter Cn | | 24D. LOCATION (City, town, or county) (State) Balto Md | |
| 25A. DATE RECEIVED BY HEALTH DEPT. MAY 1 1967 | | 25B. NAME OF REGISTRAR Robert E. Farber | |
| 25C. FUNERAL DIRECTOR John J. Renny Inc | | ADDRESS 906 | |



1
N-620

BALTIMORE CITY HEALTH DEPARTMENT

| BIRTH NO. 67 4242 | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 4242 | | | | |
|--|-------------------------|---|---|--|--|--|
| 1. NAME OF DECEASED
(Type or Print) Thaddeus W. Nawrocki
THADDEUS W. NAWROCKI | | 2. DATE AND HOUR PRONOUNCED DEAD
4-29-67 7:15 P.M. | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
1111 S. BONSAI ST. | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY BALTIMORE
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 26-36
D. STREET ADDRESS (If rural, give location) 1111 S. BONSAI ST. | | | | |
| 5. SEX
MALE | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
Single | 8. DATE OF BIRTH
Sept. 5 1941 | 9. AGE (In years last birthday)
25 | If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Longshoreman, Local #829 | | 10B. KIND OF BUSINESS OR INDUSTRY
Terminal Shipping Co. | | 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. |
| 13. FATHER'S NAME
Thaddeus Nawrocki | | 14. MOTHER'S MAIDEN NAME
Eva Korzeniewski | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
Yes, Army-1964 | | |
| 16. SOCIAL SECURITY NO.
220-38-7164 | | 17. INFORMANT ADDRESS
Father, Thaddeus Nawrocki, # 4, a, b, c, d. | | | | |
| 18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
E874.0
Overdose of narcotics
DUE TO
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) DUE TO
(C) DUE TO
INTERVAL BETWEEN ONSET AND DEATH | | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
Yes |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
Home | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
1111 S. Bonsall Street | | |
| 21D. TIME OF INJURY (Month) (Day) (Year)
FOUND: 4 29 '67 PM | | 21E. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR?
Ingested overdose of narcotics | | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>
CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>
ACTUAL SIGNATURE RUSSELL S. FISHER, M.D. DATE SIGNED 4-30-67 | | | | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 23B. DATE
May 3-1967 | | 23C. NAME OF CEMETERY or CREMATORY
St. Stanislaus | | 23D. LOCATION (City, town, or county) (State)
Baltimore, Maryland 21224 |
| 24A. DATE REC'D BY HEALTH DEPT.
MAY 1 1967 | | 24B. NAME OF REGISTRAR
Robert E. Farley | | 24C. FUNERAL DIRECTOR ADDRESS
John J. Duda, Baltimore, Maryland 21224 | | |

N 974.9 9670004250

WHITE PAPER

101

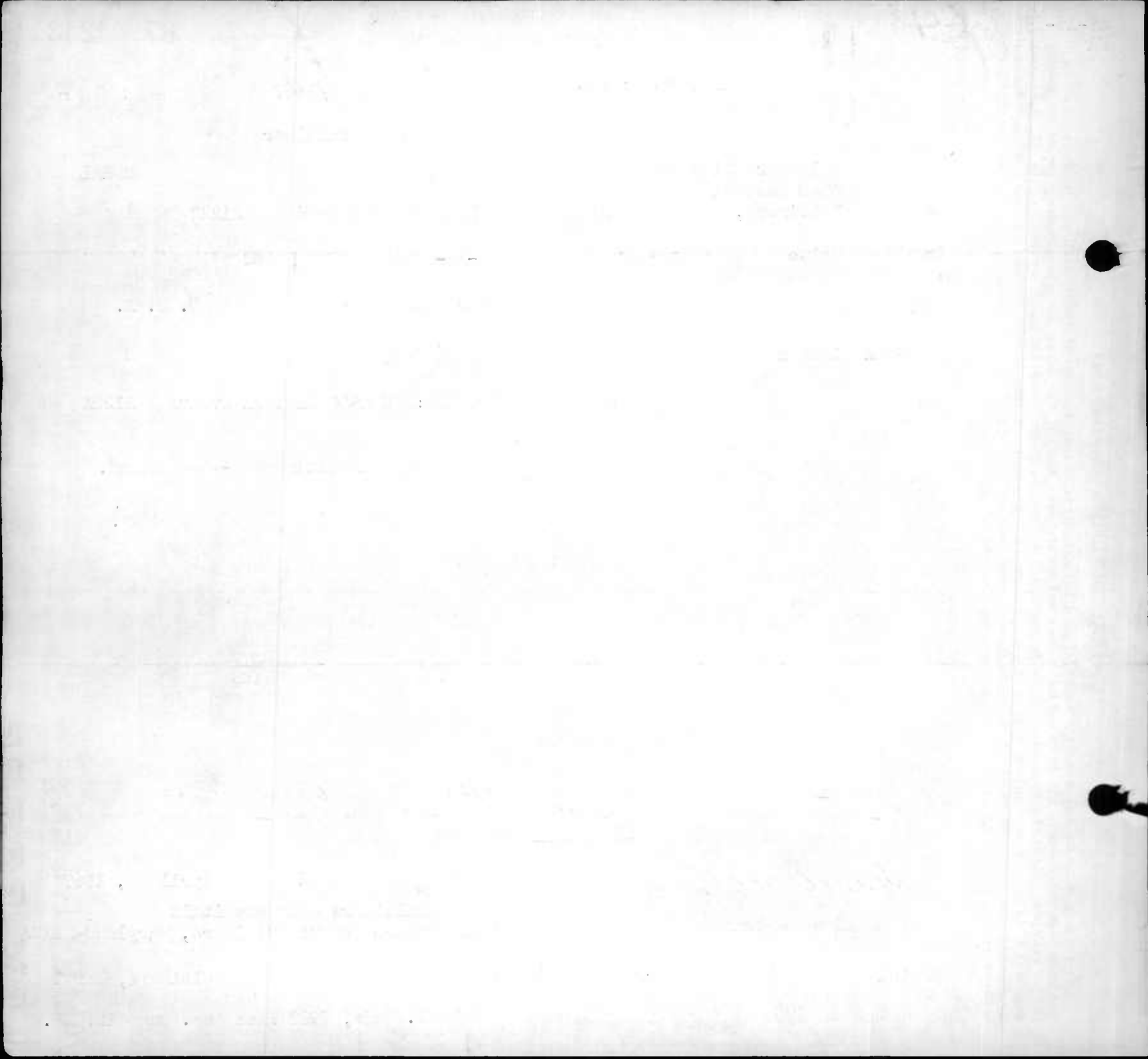
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 4243 | |
|--|--|---|--|---|--|
| BIRTH NO. 67 4243 | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) MARY MILLER - Mamie Miller | | 2. DATE AND HOUR OF DEATH
4/28/1967 6:30 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION
31 Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland 21224 | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Baltimore Co. | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Dundalk 53-00 RURAL | |
| 5. SEX Female | | 6. RACE White | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
Widowed | |
| 8. DATE OF BIRTH
9-19-1884 | | 9. AGE (In years last birthday) 82 | | 10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 13. FATHER'S NAME
John Wiseman | | 14. MOTHER'S MAIDEN NAME
Kate Betz | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT ADDRESS
RECORDS: BCM 4940 Eastern Avenue 21224 | |
| 18. 260 X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
Myocardial Infarction
DUE TO

ANTECEDENT CAUSES
Aspiration Pneumonia
DUE TO

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
? Diabetes | | | | INTERVAL BETWEEN ONSET AND DEATH
6hrs.
1hr. | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
YES | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
YES | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (1) (this hospital) attended the deceased from 4/28 19 67 to 4/28 19 67 , that (1) (was) last saw the deceased alive on 4/28 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | 23A. SIGNATURE
Richard Maffezzoli M.D.
Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | |
| 23B. DATE SIGNED
April 28, 1967 | | 23C. PHYSICIAN'S NAME (Type)
Richard Maffezzoli | | 23D. ADDRESS
Baltimore City Hospitals
4940 Eastern Avenue Baltimore, Maryland 21224 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
5/1/67 | | 24C. NAME OF CEMETERY or CREMATORY
Baltimore National Cemetery | |
| 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | | 25A. DATE REC'D BY HEALTH DEPT.
MAY 1 1967 | | 25B. NAME OF REGISTRAR
Robert E. Jackson | |
| 25C. FUNERAL DIRECTOR
John J. Duda, 7922 Wise Ave. Dundalk, Md. | | 25D. ADDRESS | | 25E. ADDRESS | |

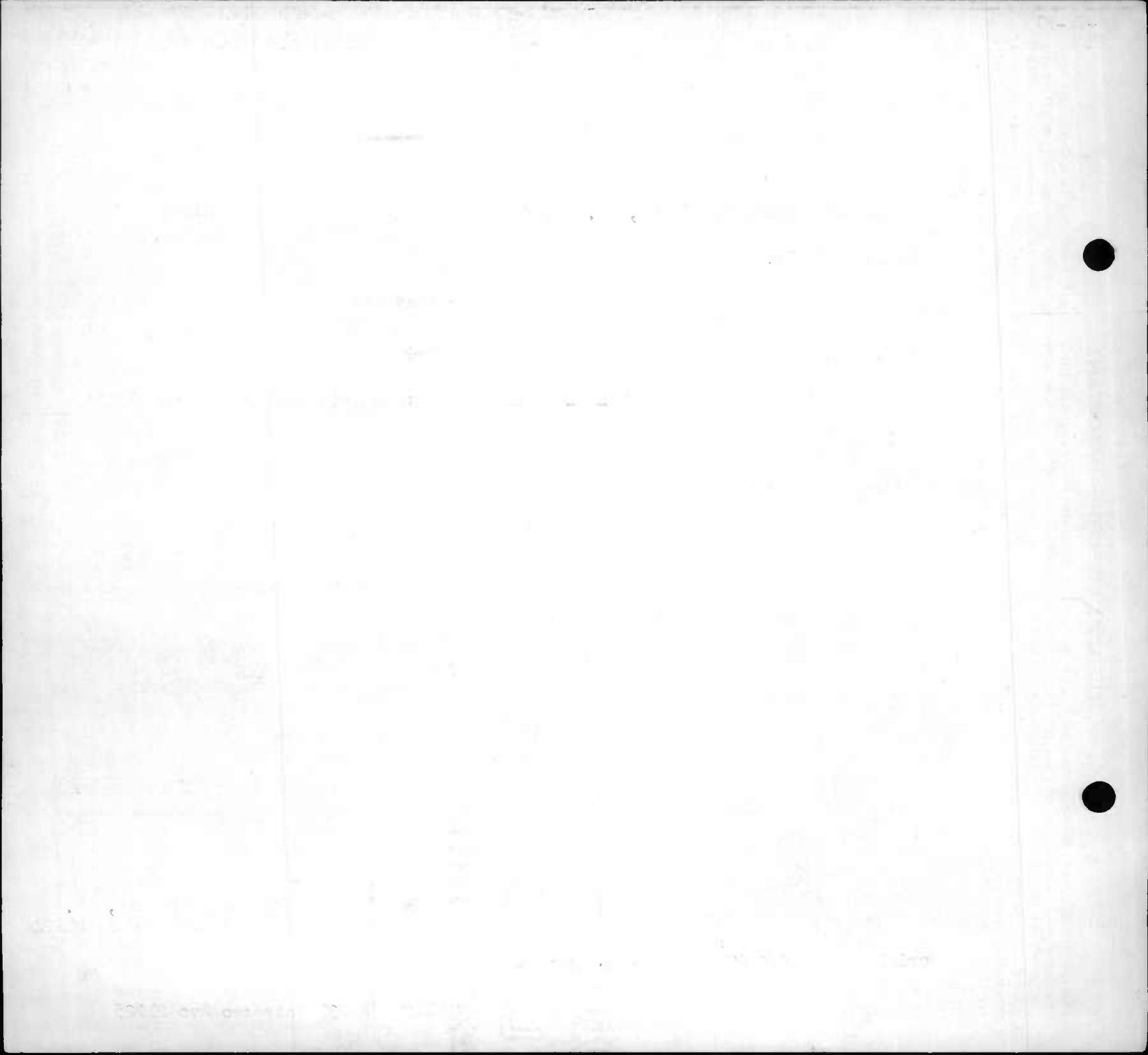


48-74-81
FR

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 4244 | |
|--|---------|---|------------------|--|--|
| CERTIFICATE OF DEATH | | | | | |
| 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| KATHERINE COLBOURNE | | 4/29/67 8:30 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location) | | A. STATE
B. COUNTY | | | |
| BALTIMORE CITY HOSPITAL
4940 Eastern Avenue Baltimore, Md. 21224 | | MD
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE
D. STREET ADDRESS (If rural, give location)
3573 FOURTH ST 21225 | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. If Under 1 Yr. Months; Days; Hours; Min. |
| Female | White | WIDOW | 2-28-80 | 87 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| | | | | Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME | | | |
| U.S.A. | | Lang, Otto | | | |
| 14. MOTHER'S MAIDEN NAME | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | |
| Unk | | No | | | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| 219-54-3359-T | | RECORDS: BCH 4940 Eastern Avenue 21224 | | | |
| 18. CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | 3 mo | | | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | Bundled | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 2 | | | | YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/21 1967 to 4/29 1967, that (I) (we) last saw the deceased alive on 4/29 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | 23A. SIGNATURE
P. J. McLEOD
23B. DATE SIGNED
4/29/67 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| P. J. McLEOD | | 4940 Eastern Avenue Baltimore, Md.
BALTIMORE CITY HOSPITAL 21224 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 5/2/67 | | Cedar Hill Cem | |
| 24D. LOCATION (City, town, or county) | | 24E. STATE | | 24F. COUNTY | |
| AA CO | | Md | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| MAY 1 1967 | | Robert E. Taylor | | McCully F H 237 Patapsco Ave 21225 | |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 4245

BIRTH NO. 67 4245

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

NORMAN C. WRIGHT, Sr.

2. DATE AND HOUR PRONOUNCED DEAD

4-24-67

7:10 PM M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

33 JOHNS HOPKINS HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

White Marsh

D. STREET ADDRESS (If rural, give location)

Rosewood Trailer Park

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
married

8. DATE OF BIRTH

Mar. 22, 1903

9. AGE (In years
last birthday)
64If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?
USA

13. FATHER'S NAME

Clinton Wright

14. MOTHER'S MAIDEN NAME

Elsie Anderson

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)
no16. SOCIAL
SECURITY NO.

17. INFORMANT

Rosewood Trailer Pk.
Mrs. Norman Wright, Pulaski Hwy. Balto.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

WERNER U. SPITZ, M.D.

M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

4-25-67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

Apr 27 1967

23C. NAME OF CEMETERY or CREMATORY

Denton

23D. LOCATION

(City, town, or county)

(State)

Denton, Caroline, Md.

24A. DATE REC'D BY HEALTH DEPT.

MAY 1 1967

24B. NAME OF REGISTRAR

Robert E. Farber

24C. FUNERAL DIRECTOR

Charles Moore Denton

ADDRESS

WILEY PAPER
MILLILEY RECORD

WILEY PAPER

WILEY PAPER

WILEY PAPER

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|---|-------------------------|--|--|
| BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 4246 | |
| BIRTH NO. 67 4246 | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 2. DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED
(Type or Print) MARY KOUGIOULIS | | 4-25-67 M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY | |
| FULL NAME OF HOSPITAL OR INSTITUTION
The Gould Convalesarium
6116 Belair Road | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
420 Hornel Street | |
| 5. SEX
Female | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widowed | 8. DATE OF BIRTH
11-30-87 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY
Housewife | 9. AGE (In years last birthday)
79 |
| 11. BIRTHPLACE (State or foreign country)
Greece | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Dimitrios Halkias | | 14. MOTHER'S MAIDEN NAME
Sofia Maronitis | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
216-30-9098 | |
| 17. INFORMANT
Mr. John Kougioulis | | ADDRESS
3311 Crossland Ave., Baltimore, Md. | |
| 18. 332X1
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Hemiplegia with recurrent cerebral vascular occlusion | | INTERVAL BETWEEN ONSET AND DEATH
approx. 4-1/2 mos. | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) Duodenal ulcer, cholecystitis with cholelithiasis.
since August 1962 | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION
none | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) person attended the deceased from August 2 19 62 to April 25 19 67 , that (I) (we) last saw the deceased alive on April 25 19 67 and that in (my) my opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | 9:45 P.M. | |
| 23A. SIGNATURE
M. B. Levin | | 23B. DATE SIGNED
4/27/67 | |
| 23C. PHYSICIAN'S NAME (Type)
M. B. Levin | | 23D. ADDRESS
218 E. University Parkway, Balto. Md. 21218 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
4-29-67 | |
| 24C. NAME OF CEMETERY or CREMATORY
Greek Orthodox Cemetery | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 1 1967 | | 25B. NAME OF REGISTRAR
Nicholas T. Matthews | |
| 25C. FUNERAL DIRECTOR
3021 Eastern Ave., Baltimore, Md. | | ADDRESS | |

6/1-1-1993

Public Notice
2007

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1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

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H-543

67 4247

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 4247

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

MARY C. HAMILTON

2. DATE AND HOUR PRONOUNCED DEAD

4-28-67

10 20 M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

FRANKLIN SQUARE HOSPITAL

36

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

MARYLAND

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

BALTIMORE

24-02

D. STREET ADDRESS (If rural, give location)

1418 BELT ST.

5. SEX

FEMALE

6. RACE

WHITE

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

4-13-25

9. AGE (In years
last birthday)

42

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

HOMEC

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Edward W. Wolff

14. MOTHER'S MAIDEN NAME

Mary McHale

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

Family - Same

18. 648.2

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Amniotic fluid embolism

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

YES

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

RUSSELL S. FISHER, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4-29-67

23A. BURIAL, CREMATION,
REMOVAL (specify)

15

23B. DATE

5/3/67

23C. NAME OF CEMETERY or CREMATORY

Baltimore Nat.

23D. LOCATION

Baltimore

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

MAY 1 1967

24B. NAME OF REGISTRAR

Robert E. Farley

24C. FUNERAL DIRECTOR

H. C. Cline - 130 E. Fort

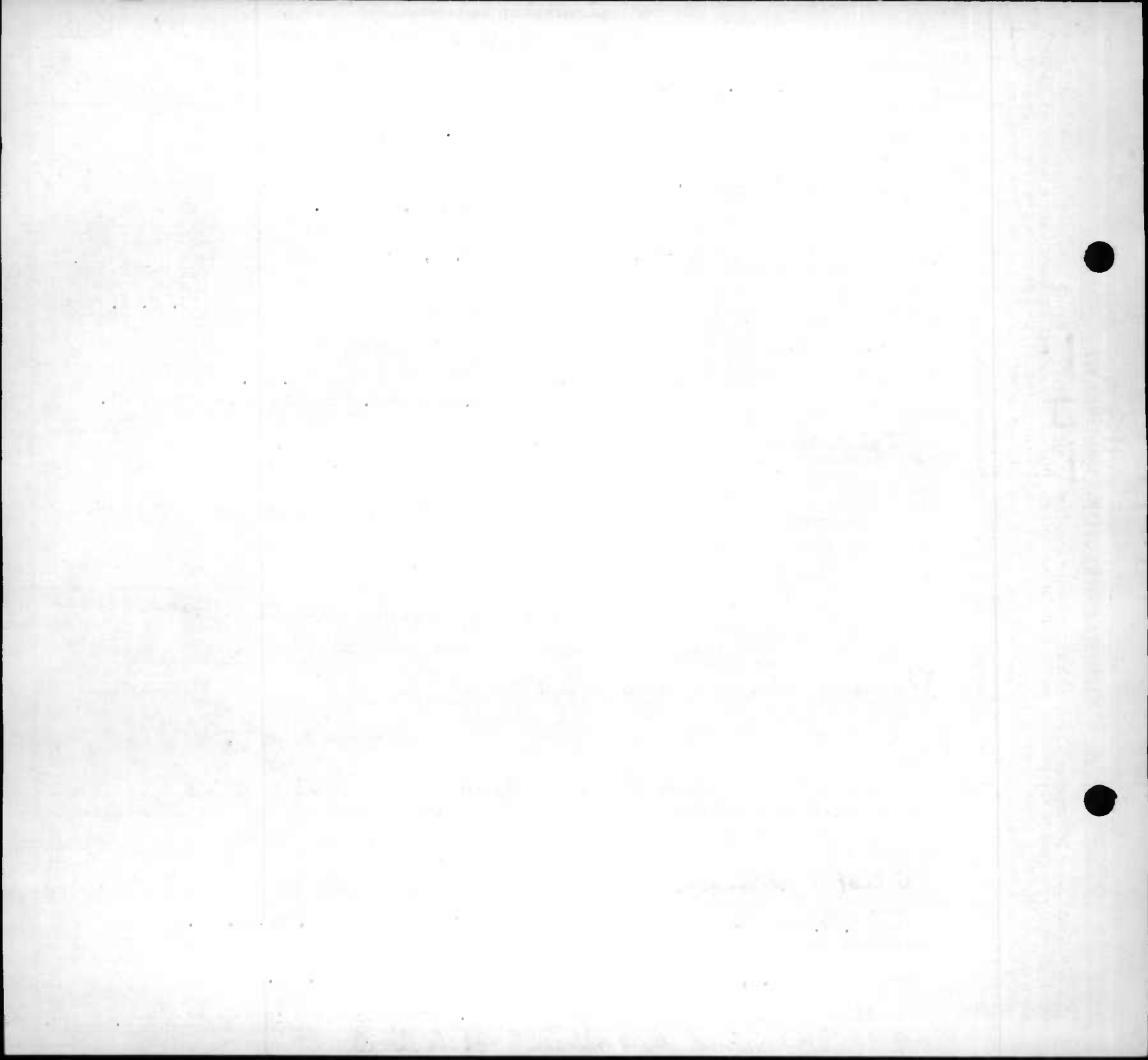
ADDRESS

525

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|------------------|---|---|-----------------------------------|--|----------------------------|--|---|--|
| CERTIFICATE OF DEATH | | | | | Registered No. 67 4248 | | | | |
| BIRTH NO. 67 4248 | | | | | | | | | |
| M.E. CASE NO. | | | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) Erna M. Pressler | | | | | 2. DATE AND HOUR OF DEATH
4/28 1040 A M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
00 231 McCurley St. | | | | | A. STATE Md.
B. COUNTY | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore 20-07 | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location)
231 McCurley St. | | | | |
| 5. SEX
Female | 6. RACE
White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
Married | | 8. DATE OF BIRTH
Feb. 10, 1899 | 9. AGE (In years last birthday)
68 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
House Wife | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Germany | | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
George Hobel | | | | | 14. MOTHER'S MAIDEN NAME
Minnie Orich | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Balto. Md.
Mr. Robert F. Pressler 231 McCurley St. | | | ADDRESS | |
| 18. I 420.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | CAUSE OF DEATH
(A) Coronary Occlusion
DUE TO
(B) Cardio-Vascular Disease
DUE TO
(C) | | | INTERVAL BETWEEN ONSET AND DEATH
Sudden
10 years | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Depressive Reaction Neuritic type 20 years | | | | | | | | | |
| 19A. DATE OF OPERATION | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 5/24 1948 to 4/28 1967, that (I) (we) last saw the deceased alive on 11/26 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
Eliot W. Johnson | | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | 23B. DATE SIGNED
4/28/67 | |
| 23C. PHYSICIAN'S NAME (Type)
E. W. Johnson | | | | | 23D. ADDRESS
M.D. 3432 Frederick Ave. Balto. Md. | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | | 24B. DATE
May 1, 1967 | | 24C. NAME of CEMETERY or CREMATORY
Loudon Park Cemetery | | | 24D. LOCATION (City, town, or county) (State)
Balto. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 1 1967 | | | 25B. NAME OF REGISTRAR
Robert E. Taylor | | 25C. FUNERAL DIRECTOR
G. Truman Schwab 3512 Frederick Ave. Balto. Md. | | | | |
| VS 150-REV. 1/1/65 Medical Examiner [Signature] | | | | | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 67 4249 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 4249 | |
|---|-------------------------|---|--|--|---|---|------------------------------|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) Kate E. AKA Lilliane Klein | | | | 2. DATE AND HOUR OF DEATH
April 27, 1967 5 P. M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
90 Century Nursing Home
102 North Paca Street | | | | A. STATE Maryland
B. COUNTY | | | |
| (If not in hospital or institution, give street address or location) | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | | | |
| | | | | D. STREET ADDRESS (If rural, give location)
102 North Paca Street | | | |
| 5. SEX
Female | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Singel | 8. DATE OF BIRTH
1877 | 9. AGE (in years last birthday)
90 | If Under 1 Yr. Months: Days | | If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Never worked | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME
John L. Klein | | | 14. MOTHER'S MAIDEN NAME
Katherine | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No None | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
Century Nursing Home Records same address | | |
| 18. 420.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Cardio-Respiratory Failure
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Ac. Myocardial Infarction
Art. CULX
Gen. arteriosclerosis | | | | CAUSE OF DEATH
INTERVAL BETWEEN ONSET AND DEATH | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Aug 24 1964 to Apr 27 1967 , that (I) (we) last saw the deceased alive on Apr 27 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
William D. Appleford | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type)
William D. Appleford | | | | 23D. ADDRESS
5501 Park Heights Dr. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
5/1/1967 | | 24C. NAME OF CEMETERY or CREMATORY
Loudon Park Cemetery | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 1 1967 | | 25B. NAME OF REGISTRAR
Robert E. Fisher | | 25C. FUNERAL DIRECTOR ADDRESS
Wm. F. Fisher & Sons Baltimore, Md. | | | |

to the University of
the University of
the University of

University of
University of
University of

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 4250 | |
|---|------------------|---|---|--|---|
| CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. 67 4250 | | | | | |
| M.E. CASE NO. E. | | | | | |
| 1. NAME OF DECEASED
(Type or Print) WARREN BURCH | | 2. DATE AND HOUR OF DEATH
4-28-67 11.35 P M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE MARYLAND
B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location)
33 THE JOHNS HOPKINS HOSPITAL | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE 12-06 | | | |
| | | D. STREET ADDRESS (If rural, give location)
40 EAST 25TH STREET 21218 | | | |
| 5. SEX
MALE | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
DIVORCED | 8. DATE OF BIRTH
2-10-10 | 9. AGE (In years last birthday)
57 | If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Cab Driver | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Baltimore, Md. | |
| 13. FATHER'S NAME
GEORGE T. BURCH | | | 14. MOTHER'S MAIDEN NAME
JESSIE BELLE SWAN | | |
| 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)
No None | | 16. SOCIAL SECURITY NO.
216-09-0229 | | 17. INFORMANT ADDRESS
Mrs. Melvin Sanders 612 North East Ave. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
421.1 I
CAUSE OF DEATH
(A) Myocardial infarction 2 days
(B) Decreased coronary blood flow 2 days
(C) Calcific aortic stenosis 2 days
replaced E Star Edwards Valve | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Marked Emphysema, Old TBC of lungs many years | | | | | |
| 19A. DATE OF OPERATION
26 April 67 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
Aortic Stenosis | | 20A. AUTOPSY? (Yes or No)
YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 27 March 1967 to 28 April 1967, that (I) (we) last saw the deceased alive on 28 April 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
William B. James | | | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type)
WILLIAM B. JAMES | | | | 23D. ADDRESS
THE JOHNS HOPKINS HOSPITAL | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
5/2/1967 | | 24C. NAME OF CEMETERY OR CREMATORY
Loudon Park Cemetery | |
| | | | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 1 1967 | | 25B. NAME OF REGISTRAR
Robert E. Jackson | | 25C. FUNERAL DIRECTOR
Wm. J. Jackson | |
| | | | | ADDRESS
Baltimore, Md. | |

025308
BIRCH. A. B. B. B.

My dear Mr. [illegible]
[illegible]
[illegible]
[illegible]
[illegible]

Yours faithfully,
[illegible]

[illegible]

21 May 1908

2899

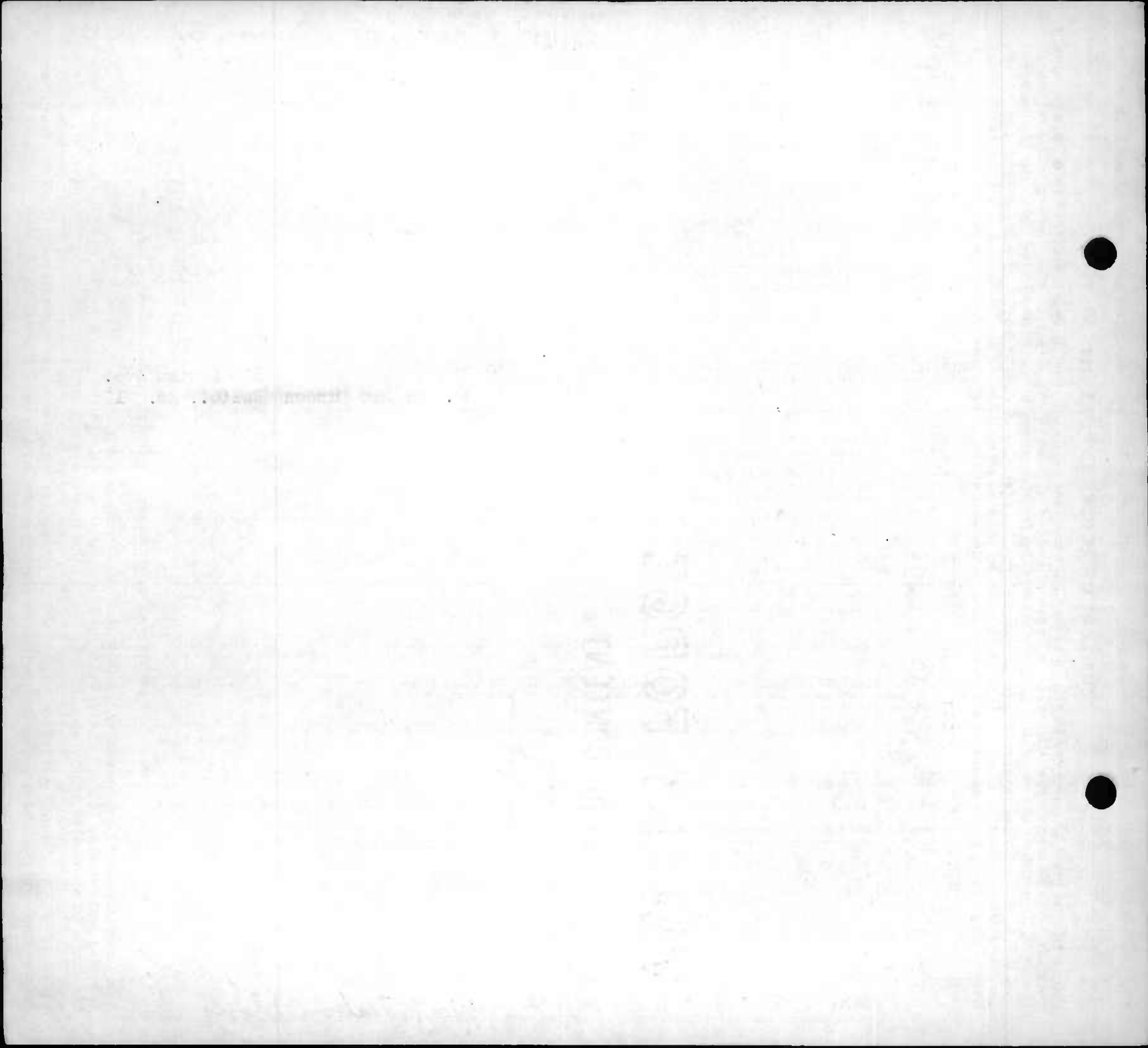
W. W. W. W.

X

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|--|--|--|--|--|
| BIRTH NO. 67 4251 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 4251 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) Bernard Dundon | | 2. DATE AND HOUR OF DEATH
4/28/67 8:22 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore 4-01 | |
| FULL NAME OF HOSPITAL OR INSTITUTION
48 Md. Gen'l Hosp | | D. STREET ADDRESS (If rural, give location)
113 W. Franklin St. | | 5. SEX M 6. RACE W 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
DIVORCED | |
| 8. DATE OF BIRTH
8/30/86 | | 9. AGE (In years last birthday)
80 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
retired | |
| 11. BIRTHPLACE (State or foreign country)
Md. | | 12. CITIZEN OF WHAT COUNTRY?
U.S. | | 13. FATHER'S NAME
William R. Dundon | |
| 14. MOTHER'S MAIDEN NAME
MARY Rust | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
218-10-6142 | |
| 17. INFORMANT
Mr. Bernard Dundon | | ADDRESS
825 Lenton Ave. Balto., Md. 12 | | 18. 420.11
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
Myocardial Infarction | |
| 19. DATE OF OPERATION
4/28/67 | | 20A. AUTOPSY? (Yes or No)
No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from April 24 1967 to April 28 1967 , that (I) (we) last saw the deceased alive on April 28 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | 23A. SIGNATURE
Dean H. Griffin M.D. | | 23B. DATE SIGNED
4/28/67 | |
| 23C. PHYSICIAN'S NAME (Type)
DEAN H. GRIFFIN M.D. | | 23D. ADDRESS | | 23E. FUNERAL DIRECTOR
Wm. J. Tabernall | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
5/1/67 | | 24C. NAME OF CEMETERY or CREMATORY
New-Cathedral Cem. | |
| 24D. LOCATION (City, town, or county) (State)
Balto., Md. | | 25A. DATE REC'D BY HEALTH DEPT.
MAY 1 1967 | | 25B. NAME OF REGISTRAR
Robert E. Taylor | |
| 25C. ADDRESS
Balto., Md. | | 25D. ADDRESS
Balto., Md. | | 25E. ADDRESS
Balto., Md. | |



1
L-560

67 4252
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 4252

M.E. CASE NO.

| | | | | | | | |
|---|-------------------------|--|---|---|--|---|---|
| 1. NAME OF DECEASED
(Type or Print)
FREDERICK W. LAHNER | | | | 2. DATE AND HOUR PRONOUNCED DEAD
April 14, 1967 1:10 P. M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
Garage rear of 2110 E. Jefferson | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE UNKNOWN (MARYLAND)
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
BALTIMORE
D. STREET ADDRESS (If rural, give location)
2204 Jefferson Street | | | |
| 5. SEX
Male | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
WIDOWED | 8. DATE OF BIRTH
10-11-1899 | 9. AGE (In years last birthday)
68 | If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
BALTIMORE, MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. |
| 13. FATHER'S NAME
UNK. | | | | 14. MOTHER'S MAIDEN NAME
UNK. | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
Yes | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
VAH: 3900 Lock Raven Boulevard | | |
| 18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Arteriosclerotic heart disease
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| II | | | | | | | |
| 19A. DATE OF OPERATION
6 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) (Min.) | | | 21E. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>

ACTUAL SIGNATURE <i>Charles S. Springate</i> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>
EXAMINER'S NAME (Type) Charles S. Springate, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED April 14, 1967
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | | | | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 23B. DATE
5-3-67 | | 23C. NAME of CEMETERY or CREMATORY
Baltimore Nat'l Cem. | | 23D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | |
| 24A. DATE REC'D BY HEALTH DEPT.
MAY 1 1967 | | 24B. NAME OF REGISTRAR
<i>Robert E. Farkley</i> | | 24C. FUNERAL DIRECTOR ADDRESS
MORTON & DYETT F.H. 1701 Laurens St. | | | |

1 9 6 7 0 0 0 4 2 6 0

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | | | | | | | | | |
|--|--|---------------------|--|--|---|------------------------------------|--|--|--|--|--|------------------------------|--|--|---|--|--|--|--|
| BIRTH NO. 67 4253 | | | | | CERTIFICATE OF DEATH | | | | | Registered No. 67 4253 | | | | | | | | | |
| M.E. CASE NO. | | | | | 2. DATE AND HOUR OF DEATH | | | | | | | | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) <i>Harry Williams</i> | | | | | April 29, 1967 | | | | | 6:10 A.M. | | | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | | | | | | | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<i>48 Maryland General Hospital</i> | | | | | A. STATE
<i>Maryland</i> | | | | | B. COUNTY | | | | | | | | | |
| (If not in hospital or institution, give street address or location) | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<i>Baltimore</i> | | | | | D. STREET ADDRESS (If rural, give location)
<i>1363 Gilmer St</i> | | | | | | | | | |
| 5. SEX
<i>M</i> | | 6. RACE
<i>N</i> | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
<i>Never married</i> | | 8. DATE OF BIRTH
<i>8/24/14</i> | | 9. AGE (In years last birthday)
<i>52</i> | | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Hours: Min. | | | | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>None</i> | | | | | 10B. KIND OF BUSINESS OR INDUSTRY
<i>Construction</i> | | | | | 11. BIRTHPLACE (State or foreign country)
<i>S. Carolina</i> | | | | | 12. CITIZEN OF WHAT COUNTRY?
<i>U. S. A</i> | | | | |
| 13. FATHER'S NAME
<i>Dave Williams</i> | | | | | 14. MOTHER'S MAIDEN NAME
<i>Lottie Johnny</i> | | | | | | | | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>NO.</i> | | | | | 16. SOCIAL SECURITY NO.
<i>251-78-3086</i> | | | | | 17. INFORMANT
<i>Claude Watts (nephew)</i> | | | | | ADDRESS
<i>3004 Chelsea Terr</i> | | | | |
| 18. <i>493X</i>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
<i>Pulmonary Infection</i>
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.
<i>Pneumonia</i> | | | | | | | | | | CAUSE OF DEATH
(A) DUE TO
(B) DUE TO
(C) DUE TO | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | | | | | | | | | |
| 19A. DATE OF OPERATION
<i>0</i> | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20A. AUTOPSY? (Yes or No) | | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | 21F. HOW DID INJURY OCCUR? | | | | | | | | | |
| 22. I certify that (I) (<i>this hospital</i>) attended the deceased from <i>April 24</i> 19 <i>67</i> to <i>April 29</i> 19 <i>67</i> , that (I) (<i>we</i>) last saw the deceased alive on <i>April 29</i> 19 <i>67</i> and that in (<i>my</i>) (<i>our</i>) opinion death occurred on the date and hour and from the causes stated above. (I) (<i>we</i>) (<i>did</i>) (<i>did not</i>) view the body after death. | | | | | | | | | | | | | | | | | | | |
| 23A. SIGNATURE
<i>W. Michael Gould</i> | | | | | | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | | 23B. DATE SIGNED
<i>4/29/67</i> | | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | | | | | | | 23D. ADDRESS
M.D. | | | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>BURIAL</i> | | | | | 24B. DATE
<i>5-3-67</i> | | | | | 24C. NAME OF CEMETERY or CREMATORY
<i>Concord Bnpl. Ch. Cem.</i> | | | | | 24D. LOCATION (City, town, or county) (State)
<i>Gaffney, S.C.</i> | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | | | | 25B. NAME OF REGISTRAR
<i>Robert E. Johnson</i> | | | | | 25C. FUNERAL DIRECTOR
<i>Mortone Dyett F.H.</i> | | | | | ADDRESS
<i>1701 Laurens</i> | | | | |

Marshall Island

1952

Marshall Island

2

David Williams

James Johnson

James Johnson

Marshall Island

April 24

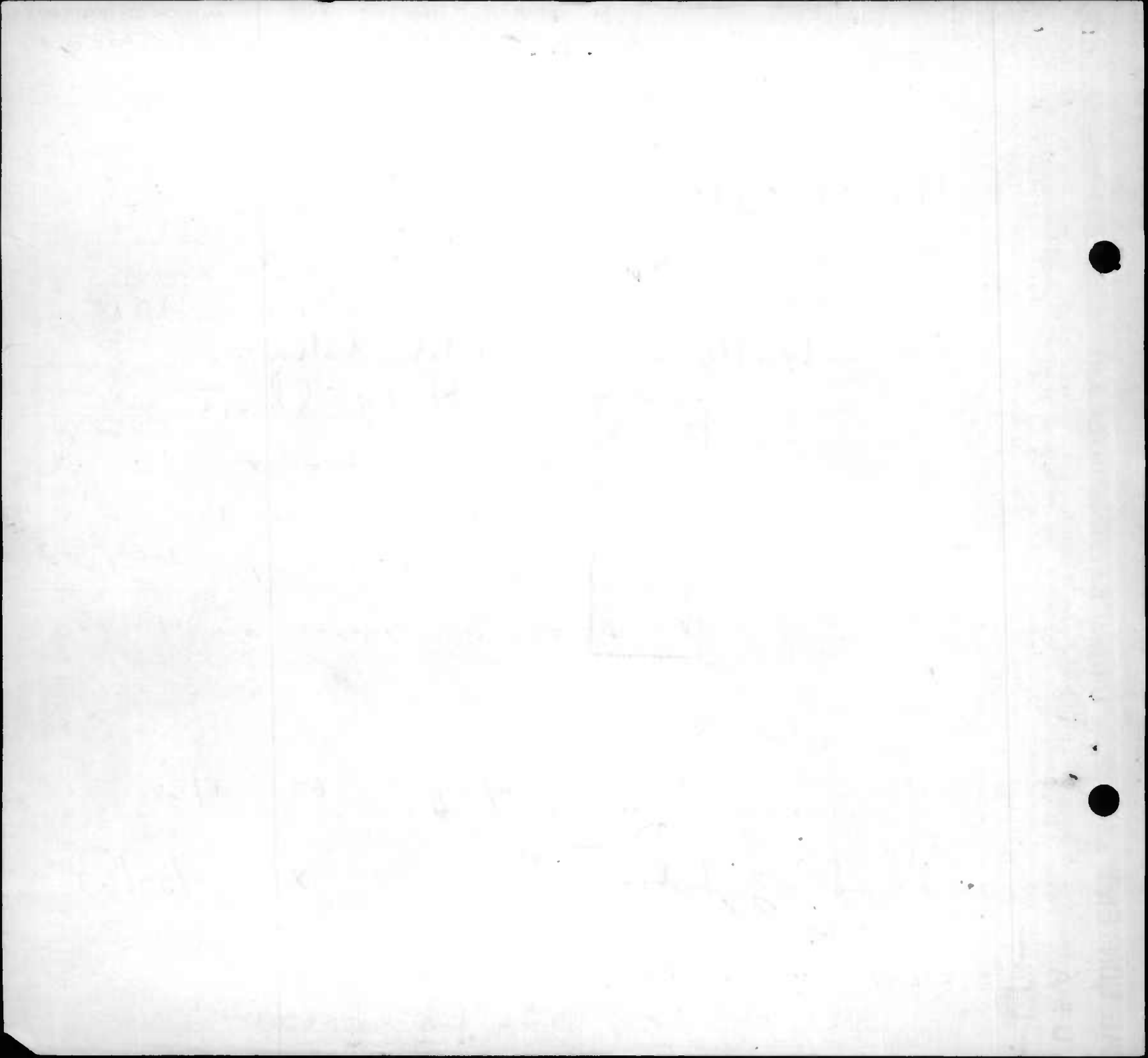
April 24

4/21/52

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

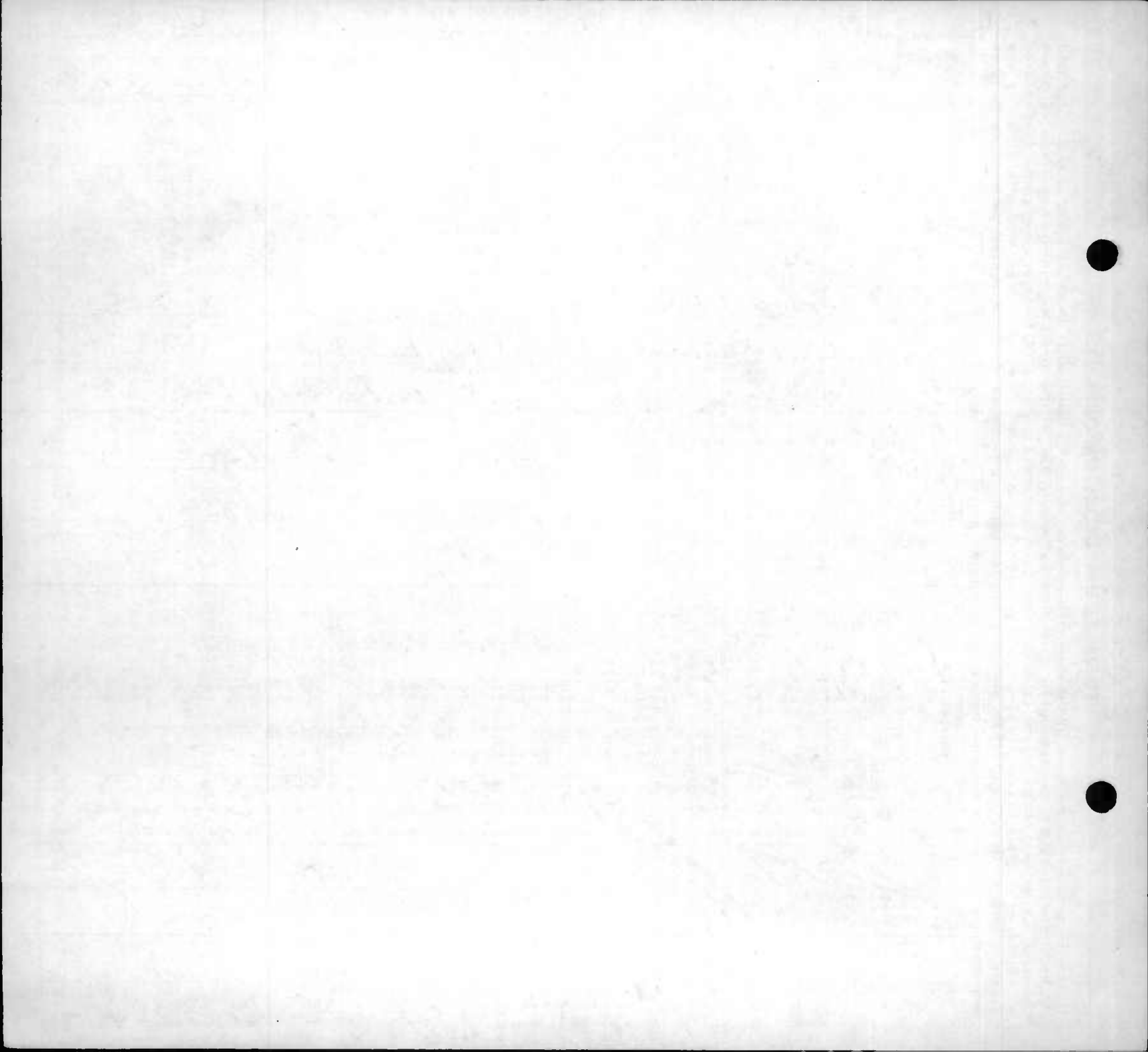
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 4254 | |
|---|-----------|--|--------------------------|--|-------------------------------------|
| BIRTH NO. 67 4254 | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Hattie Louise Rice | |
| 2. DATE AND HOUR OF DEATH 4/29/67 11:00 A.M. | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 38 University Hospital | | (If not in hospital or institution, give street address or location) | | | |
| 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | A. STATE Md B. COUNTY Balto | | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | Balto 16-07 | | | |
| D. STREET ADDRESS (If rural, give location) | | 1603 W. Hilton St. | | | |
| 5. SEX F | 6. RACE C | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) W | 8. DATE OF BIRTH 3-20-89 | 9. AGE (In years last birthday) 78 | 10. AGE (In years last birthday) 78 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) South Carolina | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME James Wallock | | 14. MOTHER'S MAIDEN NAME Clohe Coleman | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT HOSP. CHART | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES | | (A) DUE TO Cardiac Arrest | | 0 | |
| DISEASES OR CONDITIONS, if any giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO Digitalis Intoxication, w/ | | 15 yrs | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | (C) DUE TO Uremia | | 40 yrs | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? 00-00 | |
| 22. I certify that (I) (this hospital) attended the deceased from 4/28 1967 to 4/29 1967, that (I) (we) last saw the deceased alive on 4/29 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE W. E. Zink | | | | 23B. DATE SIGNED 4/29/67 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 5-3-67 | | 24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem. | |
| 24D. LOCATION (City, town, or county) (State) Balto. Md. | | 25A. DATE REC'D BY HEALTH DEPT. MAY 1 1967 | | 25B. NAME OF REGISTRAR Robert E. Taylor | |
| 25C. FUNERAL DIRECTOR | | 25D. ADDRESS | | 25E. ADDRESS 1701 Laurens | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 67 4255 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 4255 | |
|---|---------------------|--|--|--|---|
| CERTIFICATE OF DEATH | | | | | |
| M.E. CASE NO. | | | 2. DATE AND HOUR OF DEATH | | |
| 1. NAME OF DECEASED
(Type or Print) <i>Edgar Berger, Sr.</i> | | | 4/29/67 2:15 P.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<i>McGraw-Hill Hosp</i> | | | A. STATE <i>Md</i>
B. COUNTY <i>BALTO</i>
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>26-44</i>
D. STREET ADDRESS (If rural, give location) <i>12 N. Kresson St.</i> | | |
| 5. SEX
<i>M</i> | 6. RACE
<i>W</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
<i>MARRIED</i> | 8. DATE OF BIRTH
<i>12/10/1900</i> | 9. AGE (In years last birthday)
<i>56</i> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>WATCHMAN</i> | | | 10B. KIND OF BUSINESS OR INDUSTRY
<i>HALL MOTORS</i> | | 11. BIRTHPLACE (State or foreign country)
<i>Md</i> |
| 12. CITIZEN OF WHAT COUNTRY?
<i>U.S.</i> | | | 13. FATHER'S NAME
<i>Cornelius Berger</i> | | |
| 14. MOTHER'S MAIDEN NAME
<i>Lydia Leach</i> | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>Yes 215-17-6673</i> | | |
| 16. SOCIAL SECURITY NO.
<i>215-17-6673</i> | | | 17. INFORMANT
<i>wife on Adm.</i> | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
<i>420.11</i> | | | CAUSE OF DEATH
<i>Ventricular Arr. Habi</i> | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
<i>ASCVD</i> | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
<i>II</i> | | | | | |
| 19A. DATE OF OPERATION
<i>4/29</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
<i>Out down</i> | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>4-17</i> 19 <i>67</i> to <i>4-29</i> 19 <i>67</i> , that (I) (we) lost saw the deceased alive on <i>4/29</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<i>[Signature]</i> | | | | 23B. DATE SIGNED
<i>4/29/67</i> | |
| 23C. PHYSICIAN'S NAME (Type)
<i>[Signature]</i> | | | | 23D. ADDRESS
<i>[Address]</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 24B. DATE
<i>5/3/67</i> | | 24C. NAME OF CEMETERY OR CREMATORY
<i>Beth. Nat'l</i> | |
| 24D. LOCATION (City, town, or county) (State)
<i>Baltimore, Md</i> | | 24E. NAME OF REGISTRAR
<i>Robert E. Fadden</i> | | 24F. FUNERAL DIRECTOR
<i>Joseph [Signature]</i> | |
| 25A. DATE RECEIVED BY HEALTH DEPT.
<i>5/3/67</i> | | 25B. NAME OF REGISTRAR
<i>Robert E. Fadden</i> | | 25C. FUNERAL DIRECTOR
<i>Joseph [Signature]</i> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 4256 | |
|--|------------------|--|---|---|---|
| BIRTH NO. 67 4256 | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print)
J. JACKSON SMITH | | 2. DATE AND HOUR OF DEATH
5/11/67 11:30 AM | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND
MARYLAND GEN'L HOSPITAL
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD. B. COUNTY BALTIMORE Co.
C. CITY OR TOWN (If outside city limits, write RURAL and give township) GLEN ARDEN 21057 53-00
D. STREET ADDRESS (If rural, give location) LONG GREEN, RD. | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)
WIDOWED | 8. DATE OF BIRTH
11-09-89 | 9. AGE (In years last birthday)
77 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
RETIRED - SALES | | 10B. KIND OF BUSINESS OR INDUSTRY
AUTO | | 11. BIRTHPLACE (State or foreign country)
MD. | |
| 13. FATHER'S NAME
JOAN W. SMITH | | | 14. MOTHER'S MAIDEN NAME
IDA L. CURRY | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
212-09-4199 | | 17. INFORMANT
R. DIXON SMITH ADDRESS BALD Co. MD. | |
| 18. 422.11
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)
CEREBRAL VASCULAR ACCIDENT | | CAUSE OF DEATH
(A) DUE TO STROKE -
(B) DUE TO ASCVD -
(C) _____ | | INTERVAL BETWEEN ONSET AND DEATH
72 hrs | |
| II
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
HEMORRHOAGE FROM THE NOSE 7 days - | | | | | |
| 19A. DATE OF OPERATION
0 NONE | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY (Yes or No)
NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 04-25-67 19 to 05-1-67 19, that (I) (we) last saw the deceased alive on 05-1-67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Robert M. Beazley M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | | 23B. DATE SIGNED
5/11/67 | |
| 23C. PHYSICIAN'S NAME (Type)
ROBERT M. BEAZLEY M.D. | | | | 23D. ADDRESS
Maryland Gen'l Hospital | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
5-4-67 | | 24C. NAME of CEMETERY or CREMATORY
Chestnut Grove | |
| 24D. LOCATION
Baltimore Co. | | 24E. (City, town, or county) (State)
Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 2 1967 | | 25B. NAME OF REGISTRAR
Robert E. Jenkins | | 25C. FUNERAL DIRECTOR
H.W. Jenkins & Sons Co. 4905 York Rd. Balto., Md. | |

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Handwritten notes in the lower middle section of the page, including the word "Society" and other illegible text.

Handwritten notes in the lower section of the page, including the word "Society" and other illegible text.

Handwritten notes in the lower section of the page, including the word "Society" and other illegible text.

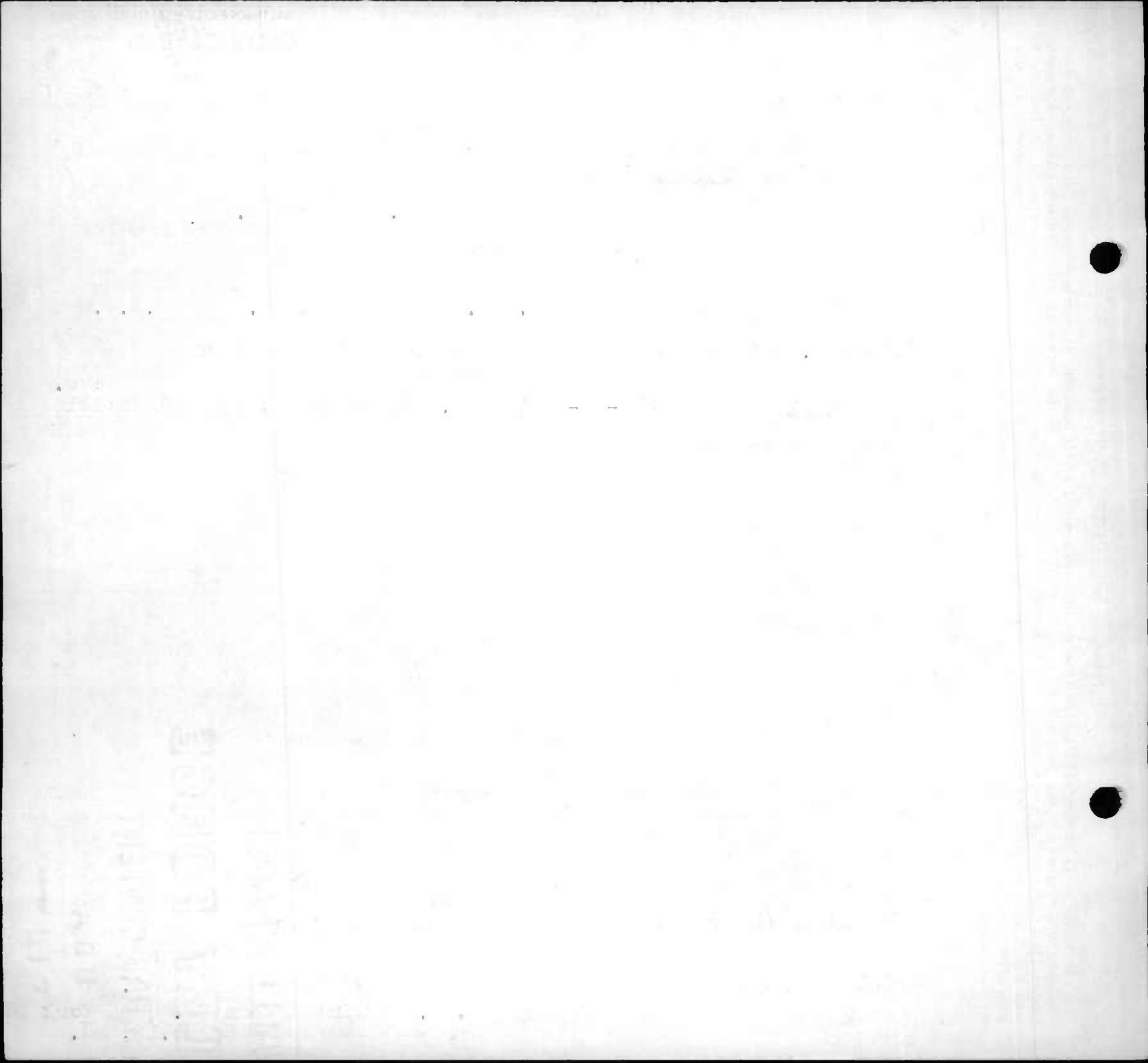
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|---------------------|---|--|--|---|--|---|------------------------------------|--|
| CERTIFICATE OF DEATH | | | | | Registered No. <u>67 4257</u> | | | | |
| BIRTH NO. <u>67 4257</u> | | | | | 2. DATE AND HOUR OF DEATH <u>4-26-67 12:53 P.M.</u> | | | | |
| M.E. CASE NO. <u>3</u> | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) <u>ELMER WHITEMORE</u> | | | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<u>37 Mercy Hospital</u> | | | | | A. STATE <u>Maryland</u> | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>Baltimore</u> | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location)
<u>1209 N. Calvert St.</u> | | | | |
| 5. SEX
<u>M</u> | 6. RACE
<u>W</u> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<u>Single</u> | | 8. DATE OF BIRTH
<u>1/12/1901</u> | 9. AGE (In years last birthday)
<u>66</u> | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Laborer</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>Continental Can. Co.</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Baltimore, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | | |
| 13. FATHER'S NAME
<u>William B. Whitemore</u> | | | | | 14. MOTHER'S MAIDEN NAME
<u>Mary Catherine Richards</u> | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>Yes 1941</u> | | | 16. SOCIAL SECURITY NO.
<u>218-07-3907</u> | | 17. INFORMANT ADDRESS
<u>Mrs. Pierce Canby, 4329 Plainfield Ave.</u> | | | | |
| 18. <u>332 XI</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
<u>Pneumonia - overwhelming</u>
DUE TO
<u>Stroke - Middle cerebral thrombosis</u>
DUE TO
<u>Anterior brain - generalized</u>
DUE TO
<u>Yrs.</u> | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>9 days.</u>
<u>9 days.</u>
<u>Yrs.</u> | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION
<u>4-23-67</u> | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
<u>Resp distress</u> | | 20A. AUTOPSY? (Yes or No)
<u>No</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
<u>No</u> | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (1) (this hospital) attended the deceased from <u>4-17 1967</u> to <u>4-26 1967</u> , that (1) (we) last saw the deceased alive on <u>4-26 1967</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE <u>J. M. Barrash</u> M.D. | | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | 23B. DATE SIGNED
<u>4-26-67</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>Jay M. BARRASH</u> | | | | | 23D. ADDRESS
<u>Mercy Hospital</u> | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>5/1/1967</u> | | 24C. NAME OF CEMETERY or CREMATORY
<u>Baltimore</u> | | 24D. LOCATION (City, town, or county) (State)
<u>Baltimore Md.</u> | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>MAY 2 1967</u> | | | 25B. NAME OF REGISTRAR
<u>Robert E. Jenkins</u> | | | 25C. FUNERAL DIRECTOR ADDRESS
<u>H. W. Jenkins & Sons Co. 4905 York Rd Balto. 12, Md.</u> | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | | | | | |
|--|--|--|--|---|--|--|--|---------------------------------|--|--|--|
| A-240 | | 67 4258 | | BIRTH NO. | | 67 4258 | | BIRTH NO. | | 67 4258 | |
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | CERTIFICATE OF DEATH | | | | | |
| Registered No. | | | | | | 67 4258 | | | | | |
| M.E. CASE NO. | | | | | | 2. DATE AND HOUR OF DEATH | | | | | |
| 1. NAME OF DECEASED
(Type or Print) | | | | | | APRIL 27, 1967 9:30 P. M. | | | | | |
| DONALD L. ASHLEY | | | | | | B. COUNTY | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | | | | | A. STATE | | | | | |
| (If not in hospital or institution, give street address or location) | | | | | | B. COUNTY | | | | | |
| Union Memorial Hospital | | | | | | MARYLAND | | | | | |
| 44 | | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | | | |
| D. STREET ADDRESS (If rural, give location) | | | | | | BALTIMORE | | | | | |
| 6012 HUNT RIDGE ROAD | | | | | | 53-00 | | | | | |
| 5. SEX | | 6. RACE | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH | | 9. AGE (In years last birthday) | | 10. UNDER 1 Yr. Months Days | |
| MALE | | WHITE | | MARRIED | | 9/11/1898 | | 68 | | 11. BIRTHPLACE (State or foreign country) | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | |
| OWNER | | ASHLEY CHEV. AUTO SALES | | MARYLAND | | U.S.A. | | Edward Ashley | | Unknown MABEL ALMONEY | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | 18. CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| No | | 216-07-0384 | | RICHARD L. ASHLEY | | 15 W. BELVEDERE AVE. | | 331X1 | | 2 days | |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | 20. ANTECEDENT CAUSES | | 21. DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | 22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | 23. MEDICAL CERTIFICATION | | 24. MEDICAL CERTIFICATION | |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | (A) cerebro-vascular accident | | (B) arteriosclerotic vascular disease. | | (C) | | 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 25. MEDICAL CERTIFICATION | | 26. MEDICAL CERTIFICATION | | 27. MEDICAL CERTIFICATION | | 28. MEDICAL CERTIFICATION | | 29. MEDICAL CERTIFICATION | | 30. MEDICAL CERTIFICATION | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from April 25, 1967 to April 27, 1967, that (I) (we) last saw the deceased alive on April 27, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | 23A. SIGNATURE | | 23B. DATE SIGNED | | 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | 23E. ADDRESS | |
| James W. Carty, Jr. | | 4/27/67 | | James W. Carty, Jr. | | The Union Memorial Hospital | | The Union Memorial Hospital | | The Union Memorial Hospital | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | | 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | |
| Entombment | | 4/29/67 | | Lorraine Park Mausoleum | | Woodlawn, Balto, Co., Md. | | MAY 2 1967 | | Robert E. Taylor, M.D. | |
| 25C. FUNERAL DIRECTOR | | 25D. ADDRESS | | 25E. ADDRESS | | 25F. ADDRESS | | 25G. ADDRESS | | 25H. ADDRESS | |
| H.W. Jenkins & Sons Co. | | 4905 York Rd. | | Balto/12, Md. | | 4266 | | 4266 | | 4266 | |

8.2 3981-16

1. L. 17 2344

THE FELLOWSHIP OF THE RING

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|---|------------------|---|---|
| BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 4259 | |
| BIRTH NO. 67 4259 | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 2. DATE AND HOUR OF DEATH 4/30/67 1:12 P.M. | |
| 1. NAME OF DECEASED (Type or Print) Goshorn, John C., Jr. | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD B. COUNTY TOWSON | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND
UNIVERSITY HOSPITAL | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) TOWSON | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
UNIVERSITY HOSPITAL | | D. STREET ADDRESS (If rural, give location) 1011 GREENACRE RD | |
| 5. SEX M | 6. RACE W | 7. MARRIED NEVER MARRIED
<input checked="" type="radio"/> WIDOWED <input type="radio"/> DIVORCED (specify) | 8. DATE OF BIRTH 4/22/1891 9. AGE (In years lost birthday) 76 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-CHEMIST | | 11. BIRTHPLACE (State or foreign country) PA. | |
| 10B. KIND OF BUSINESS OR INDUSTRY EDGEWOOD ARSENAL | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME (Unknown) GOSHORN | | 14. MOTHER'S MAIDEN NAME ? PARSON'S | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES - WWI | | 16. SOCIAL SECURITY NO. 220-20-7863 | |
| 17. INFORMANT SON - DR. GARY GOSHORN | | ADDRESS 1. GOSHORN | |
| 18. 451X1 | | CAUSE OF DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | (A) RUPTURED DISSECTING AORTIC ANEURYSM | |
| ANTECEDENT CAUSES | | (B) GENERALIZED ATHEROSCLEROTIC CARDIOVASCULAR DISEASE | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) 20 YEARS + | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | ESSENTIAL HYPERTENSION | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 3 YEARS | |
| 20A. AUTOPSY? (Yes or No) YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? 7:30 AM 1:12 PM | |
| 22. I certify that (I) (this hospital) attended the deceased from 4/30 19 67 to 4/30 19 67 , that (I) (we) last saw the deceased alive on 4/30 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE P.P. Toskes | | 23B. DATE SIGNED 4/30/67 | |
| 23C. PHYSICIAN'S NAME (Type) P.P. Toskes | | 23D. ADDRESS University Hosp. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 5/3/1967 | |
| 24C. NAME OF CEMETERY or CREMATORY Presbyterian | | 24D. LOCATION (City, town, or county) (State) Shade Gap, Pa. | |
| 25A. DATE REC'D BY HEALTH DEPT. MAY 2 1967 | | 25B. NAME OF REGISTRAR Robert E. Taylor | |
| 25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. | | ADDRESS 4905 York Rd. Balto. 12, Md. | |

Handwritten notes, possibly bleed-through from the reverse side of the page. The text is faint and mostly illegible due to the quality of the scan and the nature of the handwriting. Some words like "University" and "Department" are partially visible.

Additional handwritten notes at the bottom of the page, continuing the illegible text from the upper section. The handwriting remains consistent, and the text is too faded to transcribe accurately.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 4260 | |
|---|---|--|--|--|---|
| <div style="display: flex; justify-content: space-between;"> BIRTH NO. 67 4260 CERTIFICATE OF DEATH </div> | | | | | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED
(Type or Print) JOHANNA (JOANNA) M. PIECHOCKI | | | 2. DATE AND HOUR OF DEATH
4/30/67 10¹⁸ P.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE Md. B. COUNTY | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
35 Church Home & Hospital | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE 1-03 | | |
| | | | D. STREET ADDRESS (If rural, give location)
605 S. MONTFORD AVE | | |
| 5. SEX
F | 6. RACE
W | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married | 8. DATE OF BIRTH
4/13/1893 | 9. AGE (In years last birthday)
74 | 10. If Under 1 Yr. Months Days |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
H/W Housewife | | | 10B. KIND OF BUSINESS OR INDUSTRY
- | | 11. BIRTHPLACE (State or foreign country)
Md. |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | |
| 13. FATHER'S NAME
JACOB ZBORZYCKI | | | 14. MOTHER'S MAIDEN NAME
MARY BIALEK | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
- | | | 16. SOCIAL SECURITY NO.
212-10-1199B | | |
| | | | 17. INFORMANT ADDRESS
Mr. George Piechocki, 605 S. Montford Ave | | |
| 18. 587,01
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH
(A) Pulmonary Edema & Infarction
(B) C.H.F. due to M.I. or Glagundisease
(C) Acute Hemorrhagic Pancreatitis | | |
| INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
YES | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 4-30-1967 to 4-30-1967 , that (I) (we) last saw the deceased alive on 4-30-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
[Signature] | | | 23B. DATE SIGNED
4-30-67 | | |
| 23C. PHYSICIAN'S NAME (Type)
D. A. E. SUBER, JR. | | | 23D. ADDRESS
Church Home & Hosp. | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
5/3/67 | | 24C. NAME OF CEMETERY OR CREMATORY
Holy Rosary | |
| 24D. LOCATION
Baltimore, Maryland | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 2 1967 | | 25B. NAME OF REGISTRAR
Robert E. [Signature] | | 25C. FUNERAL DIRECTOR
M.F. SADOWSKI & SONS, 1808 EASTERN AVE | |

10-15-5

10-15-5

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10-15-5
10-15-5

10-15-5

10-15-5

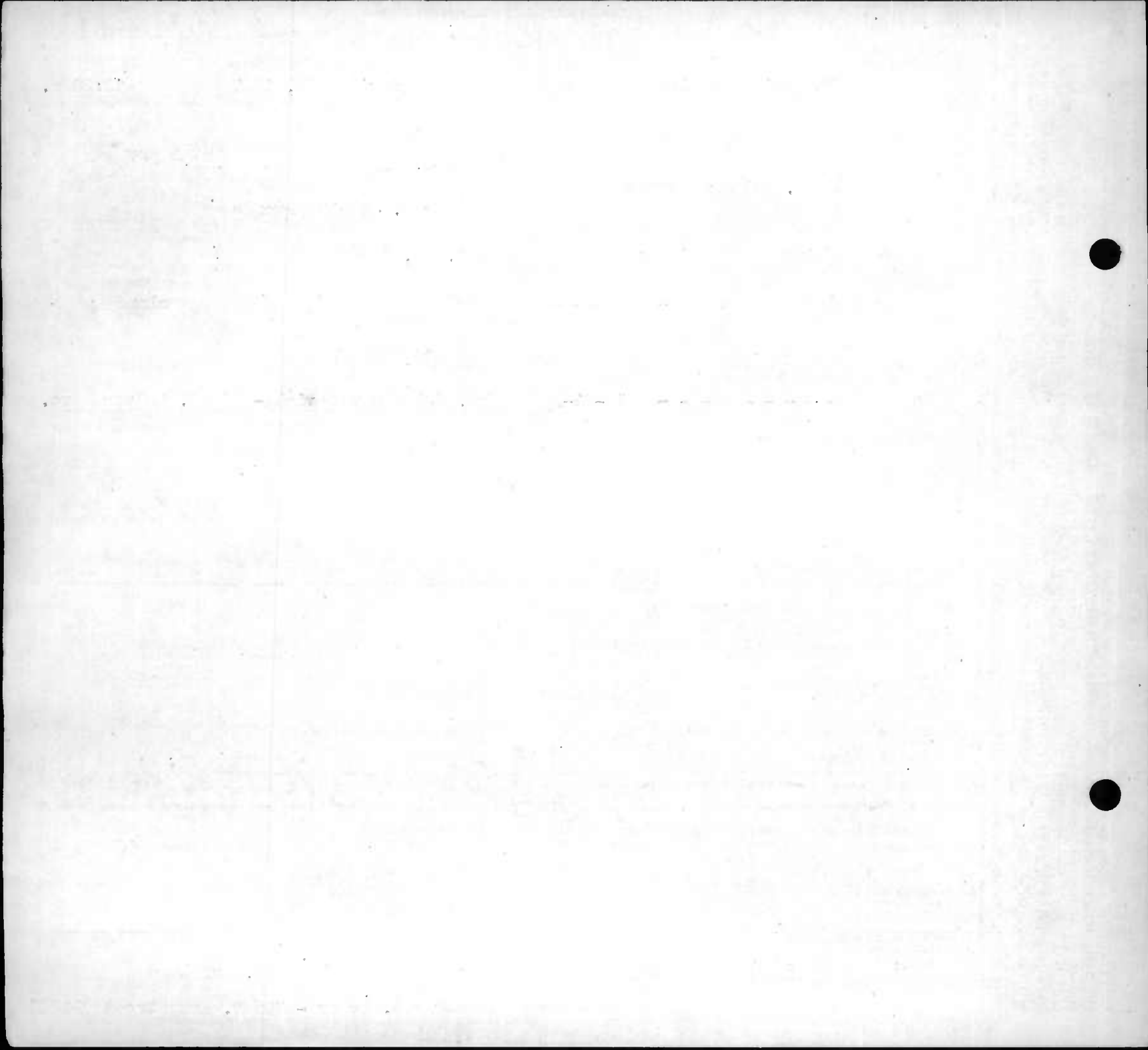
10-15-5

10-15-5

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | Registered No. 67 4261 | |
|---|---|--|---|--|--|---|-----------------------|
| BIRTH NO. 67 4261 | | | | | | | |
| M.E. CASE NO. | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) Catherino Pakula | | | | 2. DATE AND HOUR OF DEATH
April 30th, 1967 10:20 p.m. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Baltimore | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
00 646 S. Belnord Avenue | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
646 S. Belnord Avenue | | | |
| 5. SEX
Female | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widowed | 8. DATE OF BIRTH
Sept. 22, 1896 | 9. AGE (In years last birthday)
70 | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY
----- | | 11. BIRTHPLACE (State or foreign country)
Poland | | 12. CITIZEN OF WHAT COUNTRY?
Poland | |
| 13. FATHER'S NAME
Peter Kyc | | | | 14. MOTHER'S MAIDEN NAME
Agnes Bednarz | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
219-03-0189 | | 17. INFORMANT
Mrs. Helen Covacevich - 646 S. Belnord Ave. | | ADDRESS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
443 XI
Congestive Heart Failure
After chronic Hemodialysis
Hypertension & U.D. | | | | CAUSE OF DEATH
INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan 1965 to April 30 1967 , that (I) (we) last saw the deceased alive on April 28 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
Melvin J. Jaworski | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
5/1/67 | |
| 23C. PHYSICIAN'S NAME (Type)
M. J. JAWORSKI | | | | 23D. ADDRESS
5711 Eastern Ave. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
5/3/67 | | 24C. NAME OF CEMETERY or CREMATORY
Holy Rosary Cemetery | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 2 1967 | | 25B. NAME OF REGISTRAR
Robert E. Jankowski | | 25C. FUNERAL DIRECTOR
George A. Weber - 705 S. Ann Street #21231 | | ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

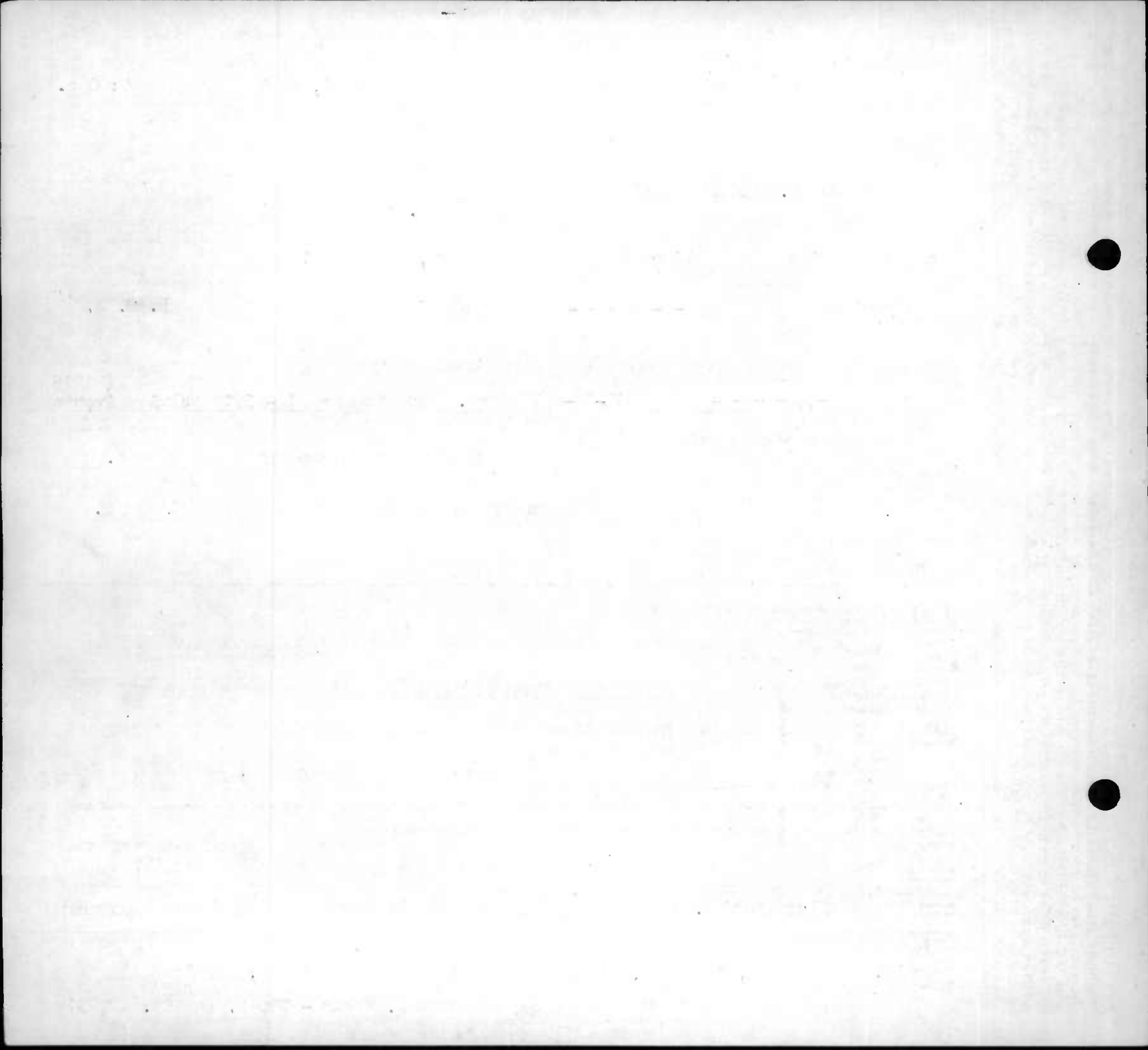
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>67 4262</u> | |
|--|-------------------------|---|--|---|---|
| BIRTH NO. <u>67 4262</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) <u>Anna Mach</u> | | 2. DATE AND HOUR OF DEATH
<u>May 1, 1967</u> <u>7:00 a.</u> M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION

<u>00 609 S. Durham Street</u> | | A. STATE <u>Maryland</u>
B. COUNTY <u>Baltimore</u>
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>
D. STREET ADDRESS (If rural, give location) <u>609 S. Durham Street</u> | | | |
| 5. SEX
<u>Female</u> | 6. RACE
<u>White</u> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<u>Widowed</u> | 8. DATE OF BIRTH
<u>July 26, 1895</u> | 9. AGE (In years last birthday)
<u>71</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
----- | | 11. BIRTHPLACE (State or foreign country)
<u>Poland</u> | |
| 13. FATHER'S NAME

<u>Szafarz</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U. S. A.</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>217-16-8779</u> | | 17. INFORMANT ADDRESS
<u>Mrs. Mary Stachurski - 3919 Belvieu Avenue #21215</u> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

<u>156.21</u>
<u>Metastatic carcinoma of Liver</u> | | CAUSE OF DEATH
(A) DUE TO
<u>Metastatic carcinoma of Liver</u>
(B) DUE TO
<u>Tumor of Kidney</u>
(C) _____ | | INTERVAL BETWEEN ONSET AND DEATH
<u>2 yrs.</u>
<u>15 yrs.</u> | |
| II
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
<u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<u>No</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>April 19 50</u> to <u>May 19 67</u> , that (I) (we) last saw the deceased alive on <u>April 21 19 67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>Clarence W. LeDoux</u> | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
<u>5/1/67</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>Clarence W. LeDoux</u> | | 23D. ADDRESS
M.D. <u>3023 Eastern Baltimore Maryland</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>May 5, 1967</u> | | 24C. NAME OF CEMETERY or CREMATORY
<u>St. Stanislaus Cemetery</u> | |
| | | | | 24D. LOCATION (City, town, or county) (State)
<u>Baltimore, Maryland</u> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>MAY 2 1967</u> | | 25B. NAME OF REGISTRAR
<u>George A. Weber</u> | | 25C. FUNERAL DIRECTOR ADDRESS
<u>705 S. Ann St. #21231</u> | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|---------|--|------------------|--|--------------------------------|
| BIRTH NO. 67 4263 | | BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | Registered No. 67 4263 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | EDWARD IGNATIUS GASKINS | | April 28, 1967 M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | Maryland | | | |
| CERTIFICATE AMENDED
3305 Westerwald Ave.
5/8/67 | | C. CITY OR TOWN (If outside city limits, with RURAL and give township) | | | |
| | | Baltimore | | | |
| | | D. STREET ADDRESS (If rural, give location) | | | |
| | | 3305 Westerwald Ave. | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. If Under 1 Yr. Months Days |
| Male | White | Married | March 23, 1897 | 70 73 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Pres. Webb Fly Screen Co. | | | | Baltimore, Maryland | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| Linsey Gaskins | | Alice Katzenberger | | U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| No | | 216-05-4002-A | | Mrs. A. Claire Harper 3307 Frisby St. 21218 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION lost. | | (A) DUE TO | | Acute Coronary Obstruction 1 day - | |
| | | (B) DUE TO | | Arteriosclerosis & Coronary 6 years | |
| | | (C) DUE TO | | Stenosis | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | no | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 7/8/61 to 4/28/67, that (I) (we) last saw the deceased alive on April 22, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. At death | | | | | |
| 23A. SIGNATURE | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED | |
| MB Levin | | | | 4/29/67 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | |
| Burial | | 5/3/67 | | Loudon Park Cemetery | |
| | | | | Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| MAY 2 1967 | | Robert E. Farley | | Wm. Cook-Brooks Towson 1050 York Rd. 21204 | |

5/8/67 - Birth certificate #54915 for Edward Ignatius Gaskins born March 23, 1894 in Baltimore, Md. to Lindsay and Alice Gaskins nee Katzenberger.

AB Carter

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 4264 | |
|---|--|--|--|---|--|
| 67 4264 | | | | CERTIFICATE OF DEATH | |
| BIRTH NO. | | M.E. CASE NO. | | 2. DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED
(Type or Print) <i>Robert J. Gibbs</i> | | | | 4-30-67 8:15 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | A. STATE B. COUNTY | |
| 4 <i>Bon Secours Hospital</i> | | | | N.Y. | |
| 5. SEX <i>m</i> 6. RACE <i>Caucasian</i> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>m - separated</i> | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | |
| | | | | N.Y. | |
| 8. DATE OF BIRTH <i>11/23/01</i> 9. AGE (In years last birthday) <i>65</i> | | | | D. STREET ADDRESS (If rural, give location) | |
| | | | | 1 <i>MARBLE HILL AVENUE</i> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| | | <i>Book Publishing</i> | | <i>Ireland</i> | |
| 13. FATHER'S NAME <i>William H. Gibbs</i> | | | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | |
| | | | | | |
| 17. INFORMANT <i>Bronx, N.Y. (63)</i> ADDRESS <i>Williams Funeral Home 5628 Broadway</i> | | | | | |
| 18. <i>420.0 + 181.0</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | | | (A) <i>Pulmonary edema</i> | |
| ANTECEDENT CAUSES | | | | (B) <i>Arteriosclerotic Heart Disease</i> | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (C) _____ | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | <i>Status post cystectomy + ileal loop bladder</i> | |
| 19A. DATE OF OPERATION <i>4-25-67</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Carcinoma of urinary bladder</i> | | 20A. AUTOPSY? (Yes or No) <i>yes</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>yes</i> | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that <i>(H)</i> (this hospital) attended the deceased from <i>4-30</i> 19 <i>67</i> to <i>4-30</i> 19 <i>67</i> , that <i>(H)</i> (we) last saw the deceased alive on <i>4-30</i> 19 <i>67</i> and that in <i>(my)</i> (our) opinion death occurred on the date and hour and from the causes stated above. <i>(H)</i> (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Jorge B. Joaquina</i> | | | | 23B. DATE SIGNED <i>4-30-67</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>JORGE B. JOAQUINO</i> | | | | 23D. ADDRESS <i>BON SECOURS HOSPITAL</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>5/5/67</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>St. Raymond's</i> | |
| 24D. LOCATION <i>Bronx, New York</i> | | 24E. DATE REC'D BY HEALTH DEPT. | | 24F. NAME OF REGISTRAR | |
| 24G. NAME OF REGISTRAR | | 24H. FUNERAL DIRECTOR <i>Wm. Cook-Brooks Inc. Baltimore, Md. 21202</i> | | 24I. ADDRESS | |

March 5

Feedback

Anticorrosive Heat Exchanger

2000

These past opportunities + ideal long blocks

25X

202

72-22-1

DE - 4

10

10

72-05-4

47-12-84 ID

n-350

67 4265

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

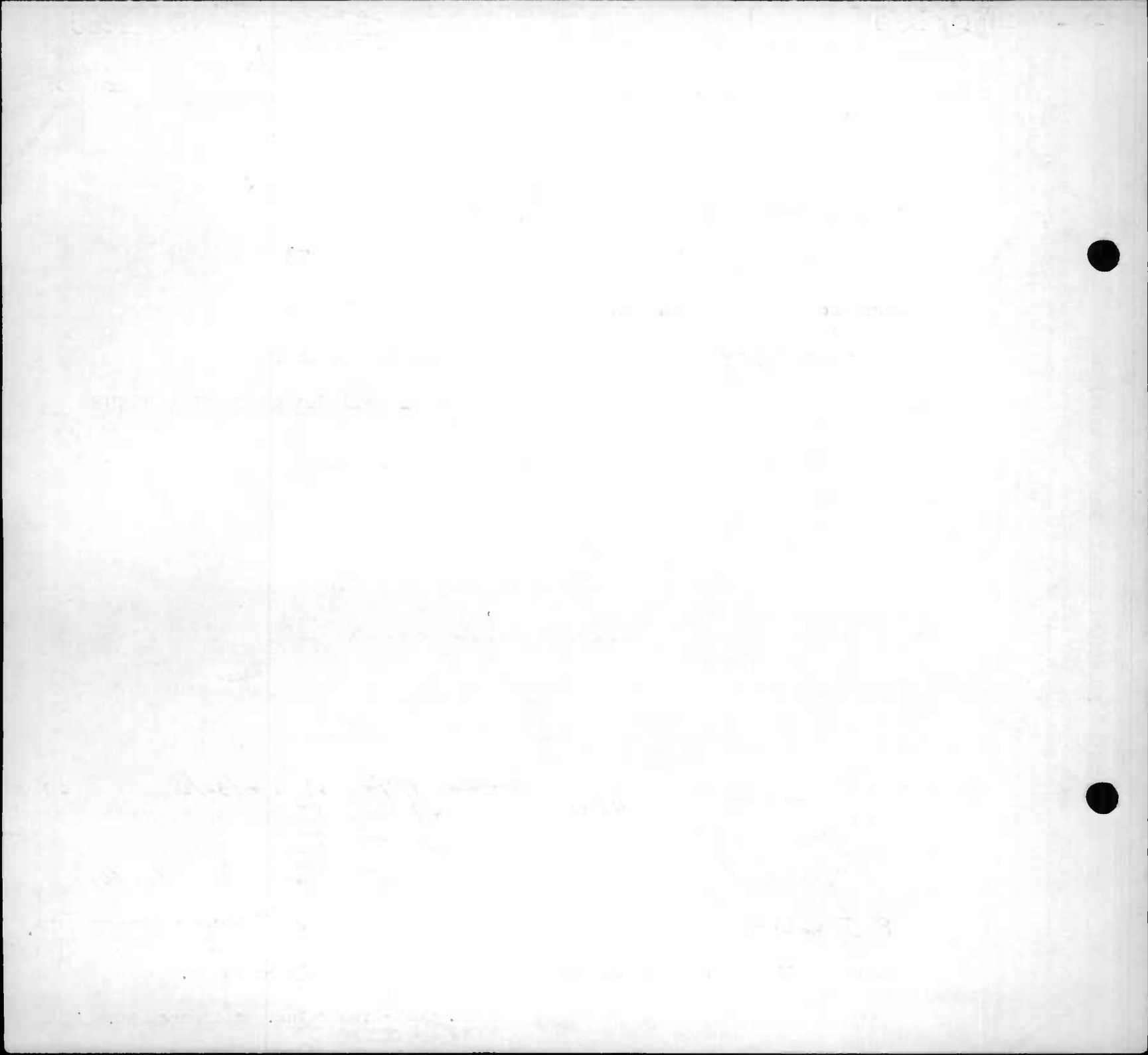
Registered No. 67 4265

| | | | |
|--|---|--|---|
| BIRTH NO. 67 4265 | | M.E. CASE NO. | |
| 1. NAME OF DECEASED
(Type or Print) MADDEN, EFFIE V | | 2. DATE AND HOUR OF DEATH
4/30/67 1:30 PM | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
31 BALT. CITY HOSP MD
4940 EASTERN AVENUE, BALTIMORE, MD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD
B. COUNTY BALTO Co.
C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE
D. STREET ADDRESS (If rural, give location) 8017 BANK ST | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED | 8. DATE OF BIRTH 4/26/89 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY Own Home | 9. AGE (In years last birthday) 78 |
| 11. BIRTHPLACE (State or foreign country) USA MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME JAMES HENRY | | 14. MOTHER'S MAIDEN NAME SARAH WHEELER | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. RECORDS-BCH-4940 EASTERN A VENUE | |
| 17. INFORMANT RECORDS-BCH-4940 EASTERN A VENUE | | ADDRESS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
Obstructive pulmonary | | INTERVAL BETWEEN ONSET AND DEATH 10 years | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Brucella | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Coronary vascular disease | | | |
| 19A. DATE OF OPERATION 2 | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) yes | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 4/19/67 to 4/30/67 19 67 , that (I) (we) last saw the deceased alive on 4/30 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE P. J. McLEOD | | 23B. DATE SIGNED 4/30/67 | |
| 23C. PHYSICIAN'S NAME (Type) P. J. McLEOD | | 23D. ADDRESS BALTO. CITY HOSP 4940 EASTERN AVE. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | 24B. DATE XX 5/3/67 | 24C. NAME OF CEMETERY OR CREMATORY Baltimore | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. |
| 25A. DATE REC'D BY HEALTH DEPT. | 25B. NAME OF REGISTRAR Wm. Cook-Brooks Inc. | 25C. FUNERAL DIRECTOR ADDRESS Baltimore, Md. 21202 | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



R-200

| | | | |
|---|--|---|--|
| 1. NAME OF DECEASED
(Type or Print) JAMES M. ROSS | | 2. DATE AND HOUR PRONOUNCED DEAD
4-29-67 11²⁵ A M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

46 LUTHERAN HOSPITAL | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY 20-01
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
BALTIMORE
D. STREET ADDRESS (If rural, give location)
531 N. PULASKI ST. | |
| 5. SEX
MALE | 6. RACE
NEGRO | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
MARRIED | 8. DATE OF BIRTH
JAN-4-1923 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
SHIPPING CLERK DEPT STORE | | 10B. KIND OF BUSINESS OR INDUSTRY | 9. AGE (In years last birthday)
44 |
| 13. FATHER'S NAME
ALEX ROSS | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
YES WWII | | 16. SOCIAL SECURITY NO.
241-28-3143 | 14. MOTHER'S MAIDEN NAME
NANNIE CARTER |
| 17. INFORMANT
ROSS | | ADDRESS
CORNOLIA ROSS 531 N PULASKI ST | |
| I. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
ARTERIOSCLEROTIC HEART DISEASE | | | INTERVAL BETWEEN ONSET AND DEATH |
| II. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION
0 | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
RUSSELL S. FISHER, M.D. | | CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>
M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| 23A. BURIAL CREMATION, REMOVAL (Specify)
REMOVAL | | 23B. DATE
5/3/67 | |
| 23C. NAME OF CEMETERY or CREMATORY
DANVILLE VA | | 23D. LOCATION (City, town, or county) (State) | |
| 24A. DATE REC'D BY HEALTH DEPT. | | 24B. NAME OF REGISTRAR | |
| 24C. FUNERAL DIRECTOR
MANHART P. HAYES | | ADDRESS
638 N GILMORE ST | |

MAY 2 1967

Robert S. Fisher

Manhart P Hayes 638 N Gilmore St

67 4266 4274

Mount Langer

H-560 67 4267

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

67 4267

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED NAOMI DORSEY HENRY
(Type or Print)

2. DATE AND HOUR OF DEATH

4/30/67

9:40 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland #212244. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland, Anne Arundel Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Millersville, Maryland

D. STREET ADDRESS (If rural, give location)

2 Pineview Avenue #21108

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widow

8. DATE OF BIRTH

3-27-91

9. AGE (In years
last birthday)

76

If Under 1 Yr.
Months DaysIf Under 24 Hrs.
Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Maintenance

10B. KIND OF BUSINESS OR INDUSTRY

Public Schools

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Peter Moore

14. MOTHER'S MAIDEN NAME

Deellear Day

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT BCH 4940 Eastern Avenue

RECORDS:

Baltimore, Maryland #21224

18. DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

(A) DUE TO

Sepsis

1 day

(B) DUE TO

Urinary Tract Infection 3 wks

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

CVA

3 wks

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

YES

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4/4 1967 to 4/30 1967.
that (I) (we) last saw the deceased alive on 4/30 1967 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Judith Hall

M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

4/30/67

23C. PHYSICIAN'S
NAME (Type)

Judith Hall

M.D.

23D. ADDRESS

4940 Eastern Avenue Baltimore, Md. #21224

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

5-5-67

24C. NAME OF CEMETERY or CREMATORY

Mt. Auburn

24D. LOCATION

(City, town, or county)

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

MAY 2 1967

25B. NAME OF REGISTRAR

Robert E. Taylor

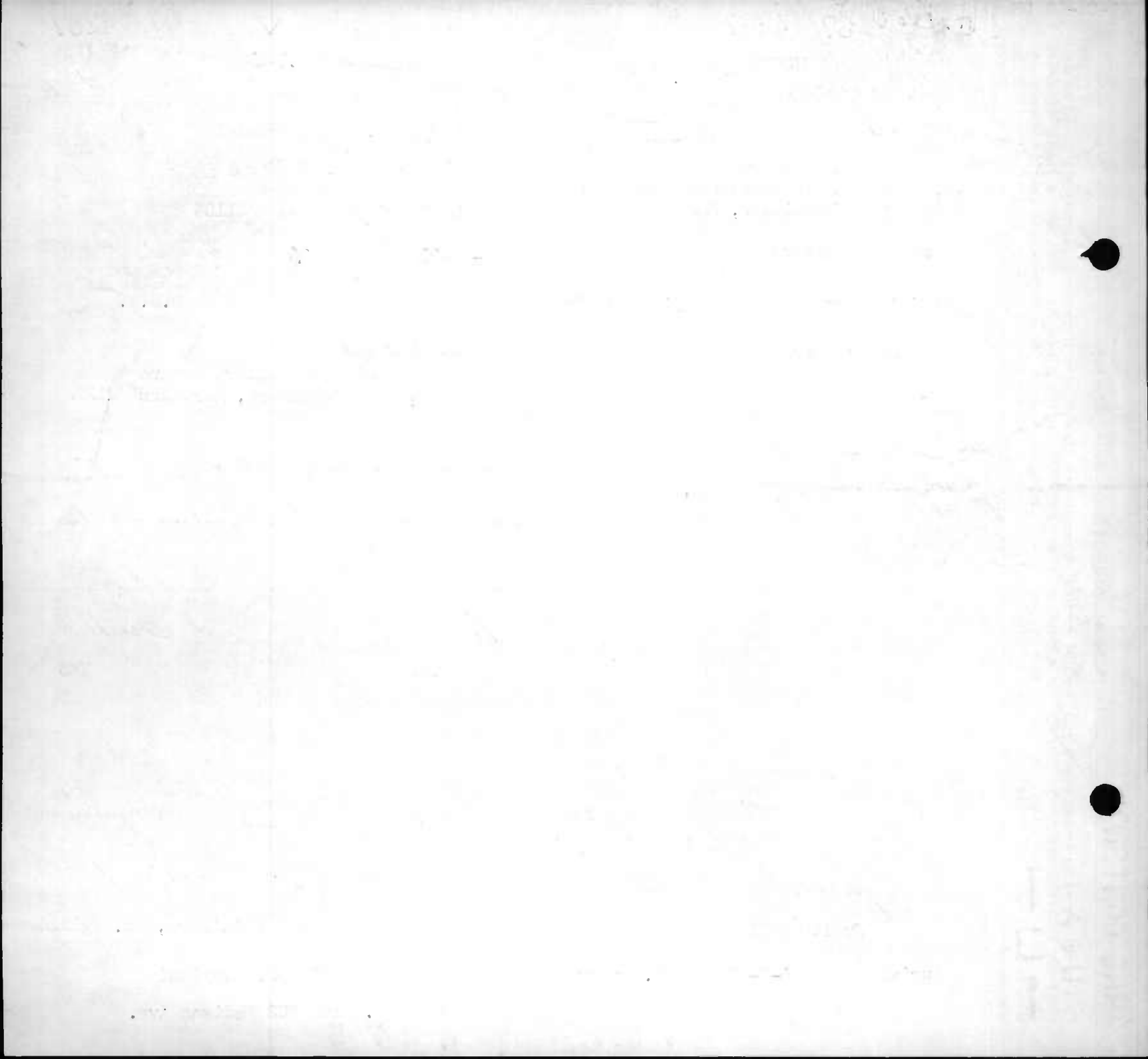
25C. FUNERAL DIRECTOR

Charles R. Law 802 Madison Ave.

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



BIRTH NO. **67 4268** MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. **67 4268**

M.E. CASE NO.

| | | | | | | | |
|---|---------------------------|--|-------------------------------------|---|--|---|----------------------------------|
| 1. NAME OF DECEASED
(Type or Print)
OTIS PLENTY | | | | 2. DATE AND HOUR PRONOUNCED DEAD
4-30-67 10:50 AM | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
1001 W. LaFayette Street - Amb. Crew #4 | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
1001 W. LaFayette Street - VE 21217 | | | |
| 5. SEX
Male | 6. RACE
Colored | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
Married | 8. DATE OF BIRTH
5-6-1893 | 9. AGE (In years last birthday)
73 | If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Chauffeur | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Houston, Virginia | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
James Plenty | | | | 14. MOTHER'S MAIDEN NAME
Louisa Farmer | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
Yes WW II | | 16. SOCIAL SECURITY NO.
220-18-9873 | | 17. INFORMANT ADDRESS
Annabell Plenty | | | |
| 18. CAUSE OF DEATH
I
422.1
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
Arteriosclerotic cardiovascular disease
(A) DUE TO
II
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) DUE TO
(C)
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>
CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ACTUAL SIGNATURE <i>Werner U. Spitz</i> M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
EXAMINER'S NAME (Type) WERNER U. SPITZ, M.D. ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>
DATE SIGNED 5-1-67 | | | | | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 23B. DATE
5-4-67 | | 23C. NAME OF CEMETERY OR CREMATORY
Baltimore National | | 23D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | |
| 24A. DATE REC'D BY HEALTH DEPT.
MAY 2 1967 | | 24B. NAME OF REGISTRAR
<i>Robert E. Fisher</i> | | 24C. FUNERAL DIRECTOR ADDRESS
Charles R. Law 802 Madison Ave. | | | |

WALLACE GORDON

RESEARCH CENTER

WALLACE GORDON

67 4269

BALTIMORE CITY HEALTH DEPARTMENT

67 4269

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ANDREW PARKER

2. DATE AND HOUR PRONOUNCED DEAD

4-24-67 4:20 PM

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

92 MARYLAND PENITENTIARY HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1624 Pressbury Street 21217

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Divorced

8. DATE OF BIRTH

25 August 1912

9. AGE (In years
last birthday)

54

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Engineer

10B. KIND OF BUSINESS OR INDUSTRY

Railway

11. BIRTHPLACE (State or foreign country)

Chicago, Illinois

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Robert Lee Parker

14. MOTHER'S MAIDEN NAME

Fanny Levi

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

218-05-1034

17. INFORMANT

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease
DUE TOANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

WERNER U. SPITZ, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4-25-67

23A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

MAY 1 1967

23C. NAME OF CEMETERY or CREMATORY

23D. LOCATION

(City, State, County)

(State)

24A. DATE REC'D BY HEALTH DEPT.

MAY 2 1967

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

MORTUARY SERVICE - BCHD

WALLACE COLLEGE

WALLACE COLLEGE

WALLACE COLLEGE

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 4270 | |
|--|------------------|--|-------------------------------|--|---|
| BIRTH NO. 67 4270 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) Johnson, Perry Lee | | 2. DATE AND HOUR OF DEATH
April 26, 1967 8:30 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE Maryland
B. COUNTY 10-01 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | |
| FULL NAME OF HOSPITAL OR INSTITUTION
31 Baltimore City Hospitals
4940 Eastern Avenue, Baltimore, Maryland | | D. STREET ADDRESS (If rural, give location)
1111 Forrest Street | | 21202 | |
| 5. SEX
Male | 6. RACE
Negro | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
Never Married | 8. DATE OF BIRTH
9-10-1920 | 9. AGE (In years last birthday)
46 | If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Labor | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
North Carolina | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
P Bennie Johnson | | 14. MOTHER'S MAIDEN NAME
Deila Ashe | |
| 15. Was Deceased Ever in U. S. Armed Forces (Yes, no or unknown) (If yes, give war or dates of service)
YES | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Records: BCM-4940 Eastern Avenue 21224 | |
| 18. 199.2 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthermia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) DUE TO Metastatic Carcinoma (Choriocarcinoma)
(B) DUE TO
(C) | | INTERVAL BETWEEN ONSET AND DEATH
4 y. | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/9 1967 to 4/26 1967, that (I) (we) last saw the deceased alive on 4/26 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Clayton L. Moravec | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
4/26/67 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS
M.D. 4940 Eastern Avenue, Baltimore, Maryland 21224 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
5-1-67 | | 24C. NAME OF CEMETERY or CREMATORY
Baltimore Natl. Cem. | |
| 24D. LOCATION (City, town, or county) (State)
Balto Md | | 25A. DATE REC'D BY HEALTH DEPT.
MAY 2 1967 | | 25B. NAME OF REGISTRAR
Robert E. Bailey | |
| 25C. FUNERAL DIRECTOR
Clayton Moravec | | ADDRESS
10000 Community Dr | | | |

Mr. J. H. (Bain)
(The Treasurer)

100 1/2
100 1/2

100 1/2

100 1/2
100 1/2

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 67 4271 | |
|---|--|--|--|--|--|
| CERTIFICATE OF DEATH | | | | Registered No. | |
| BIRTH NO. 67 4271 | | M.E. CASE NO. | | 2. DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED
(Type or Print) JACKSON ELIZABETH | | 4/30/67 16 ¹⁰ pm M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
THE JOHNS HOPKINS HOSPITAL
33 | | A. STATE MARYLAND
B. COUNTY 3-01 | | | |
| 5. SEX FEMALE | | 6. RACE NEGROID | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE | |
| 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | | 8. DATE OF BIRTH 2-25-95 | | 9. AGE (In years lost birthday) 72 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) South Carolina | |
| 13. FATHER'S NAME
CARTER Daniel | | 14. MOTHER'S MAIDEN NAME
Allen Alice | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ORDER JACKSON | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
260X I
ACUTE MYOCARDIAL INFARCT | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH 30 min. | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DIABETES MELLITUS | | 18 mo. | |
| | | (C) METABOLIC ACIDOSIS | | 6 hr. | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) No | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 4/30 1967 to 4/30 1967, that (I) (we) last saw the deceased alive on 4/30 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE C. H. BROWN, III, M.D. | | | | 23B. DATE SIGNED 4/30/67 | |
| 23C. PHYSICIAN'S NAME (Type) C.H. BROWN 3RD | | 23D. ADDRESS THE JOHNS HOPKINS HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 5-3-67 | | 24C. NAME of CEMETERY or CREMATORY Baito Nat Cent | |
| 24D. LOCATION (City, town, or county) Baito Md | | 24E. STATE (State) Md | | 25A. DATE REC'D BY HEALTH DEPT. MAY 2 1967 | |
| 25B. NAME OF REGISTRAR Robert E. Jackson, M.D. | | 25C. FUNERAL DIRECTOR ADDRESS Chas. Wilson - Brantley Inc | | | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|---------------------------|--|---|---|--|---|--|---|--|
| BIRTH NO. 67 4272 | | | | | REGISTERED NO. 67 4272 | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) VIOLA SPRIGGS | | | | | 2. DATE AND HOUR OF DEATH
4-29-67 5:00 P.M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
THE JOHNS HOPKINS HOSPITAL
33 | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE
D. STREET ADDRESS (If rural, give location)
1035 ORLEANS ST. | | | | |
| 5. SEX
FEMALE | 6. RACE
NEGROID | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
WIDOWED | | 8. DATE OF BIRTH
6-22-32 | 9. AGE (In years last birthday)
34 | If Under 1 Yr. Months: Days | | If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Virginia | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
FRED LANE | | | | 14. MOTHER'S MAIDEN NAME
LUCILLE Parker | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
no | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
Corrine M. Lane Longbranch 12 | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
445X
Acute renal failure | | | | | INTERVAL BETWEEN ONSET AND DEATH
5 days | | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
malignant hypertension
year | | | | | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION
4-23-67 | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
SUSPECTED MESENTERIC THROMBOSIS | | | 20A. AUTOPSY? (Yes or No)
YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (1) (this hospital) attended the deceased from 4/21 19 67 to 4/29 19 67 , that (1) (we) last saw the deceased alive on 5 PM 4/29 19 67 and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
Tah-Hsiung Hsu M.D. | | | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
4/29/67 | |
| 23C. PHYSICIAN'S NAME (Type)
TAH-HSIUNG HSU M.D. | | | | | | 23D. ADDRESS
The Johns Hopkins Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
5-3-67 | | 24C. NAME OF CEMETERY OR CREMATORY
Not return Cat | | 24D. LOCATION (City, town or county) (State)
Baltimore | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 2 1967 | | | 25B. NAME OF REGISTRAR
Robert E. Taylor | | | 25C. FUNERAL DIRECTOR
Shropshire | | ADDRESS
Shropshire | |

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4/24/67
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 67 4273 | | BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | Registered No. 67 4273 | |
|--|-------------------------|---|------------------------------------|--|---|
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) Frank C. Geissinger GEISINGER | | 2. DATE AND HOUR OF DEATH
4/28/67 7:15A M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Frederick County | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Walkersville 60-00 | |
| FULL NAME OF HOSPITAL OR INSTITUTION
The Johns Hopkins Hospital | | D. STREET ADDRESS (If rural, give location)
-- | | | |
| 5. SEX
Male | 6. RACE
White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)
NEVER MARRIED | 8. DATE OF BIRTH
7/12/99 | 9. AGE (In years last birthday)
67 | If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Foundry Worker | | 10B. KIND OF BUSINESS OR INDUSTRY
Cambridge Rubber Co. | | 11. BIRTHPLACE (State or foreign country)
Maryland | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. |
| 13. FATHER'S NAME
Charles F. GEISINGER | | 14. MOTHER'S MAIDEN NAME
Alva Colver Cover | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
217-12-2831 | | 17. INFORMANT
Mrs George Flickinger, Walkersville, Md. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
CAUSE OF DEATH
(A) cardiac arrest - sepsis
(B) uremia and/or bronchopneumonia
(C) massive surgical stress | | INTERVAL BETWEEN ONSET AND DEATH
4 days unknown | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
massive surgical stress | | | | | |
| 19A. DATE OF OPERATION
4/3/67 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
Bleeding Gastric Ulcer | | 20A. AUTOPSY? (Yes or No)
Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
<input type="checkbox"/> | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
<input type="checkbox"/> | |
| 21D. TIME OF INJURY (APPROX.)
<input type="checkbox"/> | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR?
<input type="checkbox"/> | |
| 22. I certify that (1) this hospital attended the deceased from 4/3 1967 to 4/28 1967 , that (2) we last saw the deceased alive on 4/28 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) we (did) not view the body after death. | | | | | |
| 23A. SIGNATURE
Floyd T. Bryan | | | | 23B. DATE SIGNED
4/28/67 | |
| 23C. PHYSICIAN'S NAME (Type)
Floyd T. Bryan | | 23D. ADDRESS
The Johns Hopkins Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
5/1/67 | | 24C. NAME OF CEMETERY or CREMATORY
Mt. Olivet Cemetery | |
| 24D. LOCATION
Frederick, Md. | | 25A. DATE REC'D BY HEALTH DEPT.
MAY 2 1967 | | | |
| 25B. NAME OF REGISTRAR
Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR
F. C. Barton, Walkersville, Md. | | | |

Handwritten (left) of the subject
 X 5-11-21 2-21 11

50

25V

Handwritten (right) of the subject
 X 5-11-21 2-21 11

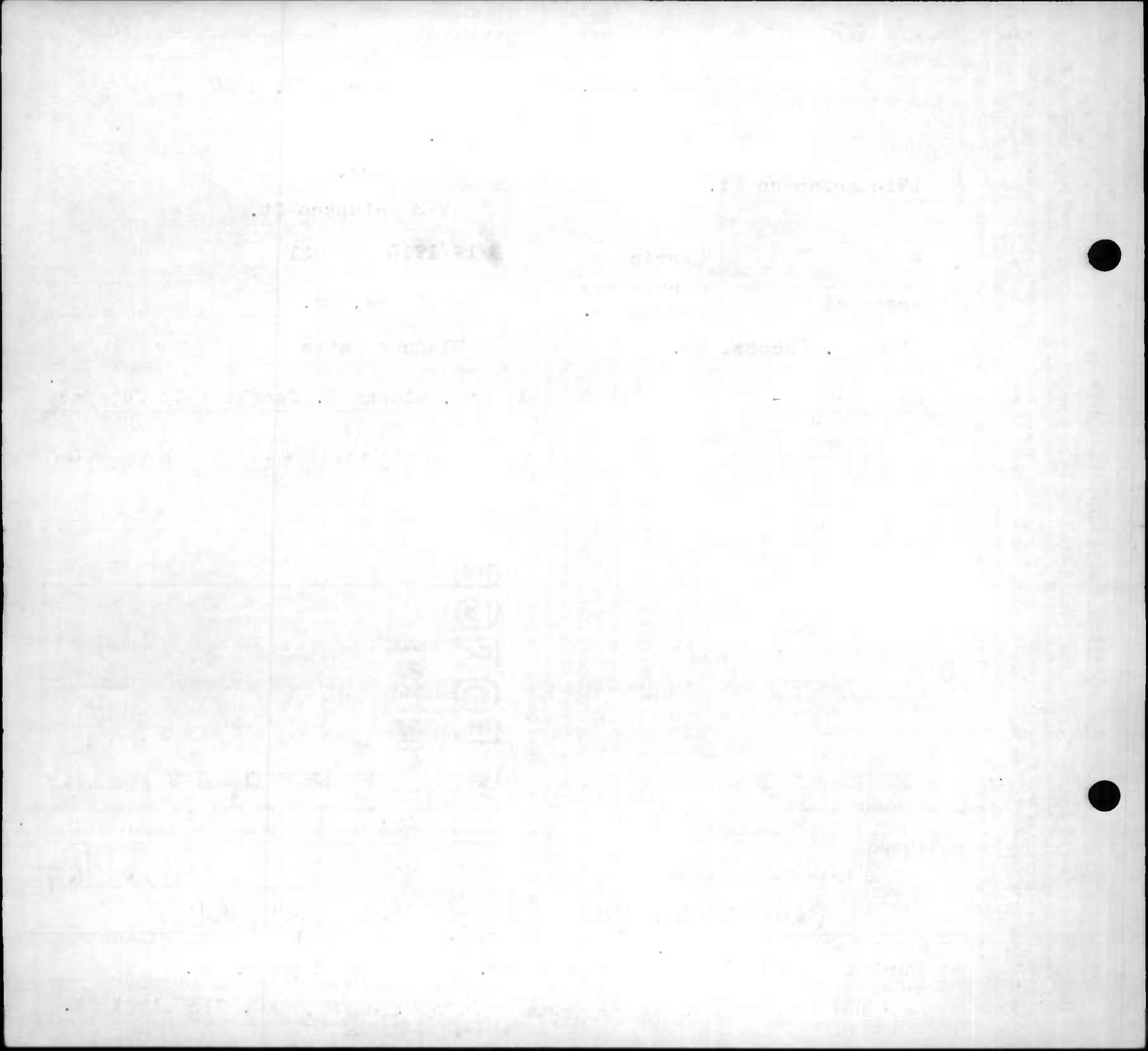
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | Registered No. 67 4274 | |
|--|---|--|---|--|---|--|------------------------------|
| BIRTH NO. 67 4274 | | | | | | | |
| M.E. CASE NO. | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) JOHN EDWARD JACOBS, JR. | | | | 2. DATE AND HOUR OF DEATH
April 27, 1967 M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location)

1713 Patapsco St. | | | | A. STATE
Md. | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore, | | | |
| | | | | D. STREET ADDRESS (If rural, give location)
1713 Patapsco St. | | | |
| 5. SEX
M | 6. RACE
W | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married | 8. DATE OF BIRTH
8/19/1915 | 9. AGE (In years last birthday)
51 | If Under 1 Yr. Months: Days: Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Personnel | | | 10B. KIND OF BUSINESS OR INDUSTRY
Curtis Bay Towing Co. | | 11. BIRTHPLACE (State or foreign country)
Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME
John E. Jacobs, Sr. | | | 14. MOTHER'S MAIDEN NAME
Blanche Watts | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | 16. SOCIAL SECURITY NO.
217 05 1211 | | 17. INFORMANT ADDRESS
Mrs. Aldean S. Jacobs 1713 Patapsco St. | | |
| 18. 157X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | | | CAUSE OF DEATH
(A) Carcinoma Pancreas
DUE TO | | INTERVAL BETWEEN ONSET AND DEATH
8 months | |
| | | | | (B) _____
DUE TO | | (C) _____ | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan 1966 to April 27 1967 , that (I) (we) last saw the deceased alive on April 26 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
Paul Sehnfeld | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
4/28/67 | |
| 23C. PHYSICIAN'S NAME (Type)
Paul Sehnfeld | | | | 23D. ADDRESS
2301 Annapolis Rd | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
5/1/67 | | 24C. NAME OF CEMETERY or CREMATORY
Cedar Hill Cem. | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 2 1967 | | 25B. NAME OF REGISTRAR
Robert E. Faley | | 25C. FUNERAL DIRECTOR
JOHN F. DENNY, INC. | | ADDRESS
715 Light St. | |



1
R-516

67 4275
BIRTH NO.
M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

67 4275

| | | | | | | | |
|---|-------------------------|--|--------------------------------------|--|--|--|--|
| 1. NAME OF DECEASED
(Type or Print)
EMMA RAMAPURAM | | | | 2. DATE AND HOUR PRONOUNCED DEAD
April 26, 1967 3:35 P.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
42 Sinai Hospital | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE Maryland
B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 3207 Kyser Road | | | |
| 5. SEX
Female | 6. RACE
White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
Married | 8. DATE OF BIRTH
4/26/1935 | 9. AGE (In years last birthday)
32 | If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Medical Secretary | | 10B. KIND OF BUSINESS OR INDUSTRY
Phys. Office | | 11. BIRTHPLACE (State or foreign country)
New York City | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Antonio Ferreira | | | | 14. MOTHER'S MAIDEN NAME
Ena Ferreira Nee Cortez | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
055-28-3841 | | 17. INFORMANT ADDRESS
Dr. George M. Ramapuram-3207 Keyser Rd. 21208 | | | |
| 18. CAUSE OF DEATH
E823.4
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
Hemothorax
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
Rupture of Aorta. | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
Yes | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
Street | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
Balto. Beltway & Jones Falls Expressway | | | |
| 21D. TIME OF INJURY (APPROX.)
4 26 '67 P.m. | | 21E. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR?
Driver of auto which ran off roadway. | | | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>
ACTUAL SIGNATURE Charles S. Petty M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>
EXAMINER'S NAME (Type) Charles S. Petty ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 4/27/67 | | | | | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 23B. DATE
5/1/67 | | 23C. NAME OF CEMETERY or CREMATORY
Druid Ridge | | 23D. LOCATION (City, town, or county) (State)
Pikesville, Md. 21208 | |
| 24A. DATE REC'D BY HEALTH DEPT.
MAY 2 1967 | | 24B. NAME OF REGISTRAR
Robert E. Farley | | 24C. FUNERAL DIRECTOR ADDRESS
Loring Byers-8728 Liberty Rd. Randallstown | | | |

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WALLING FOLIORE
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. | |
|--|---------|--|------------------|--|--------------------------------|
| 67 4276 | | CERTIFICATE OF DEATH | | 67 4276 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED | | | |
| | | Francis E. Peck | | | |
| 2. DATE AND HOUR OF DEATH | | April 26th, 1967 10:50 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE B. COUNTY | | | |
| Saint Agnes Hospital | | Maryland | | | |
| Caton & Wilkens Aves | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| 2129 | | Baltimore | | | |
| D. STREET ADDRESS (If rural, give location) | | 500 Milford Mill Rd. 21208 | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. If Under 1 Yr. Months Days |
| M | W | Married | Jan. 5, 1891 | 76 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Machine Operator | | Good Year Rubber Co. | | Myersdale, Penna. | |
| 12. CITIZEN OF WHAT COUNTRY? | | U.S.A. | | | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | | |
| Jonas Peck | | Elizabeth Sass | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| No | | 219-93-9950 | | Mrs. Athol V. Peck- 500 Milford Mill Rd. 21208 | |
| 18. CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | (A) Cerebro-vascular accident | | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (B) DUE TO | | | |
| ANTECEDENT CAUSES | | (C) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| Esther Edery M.D. | | | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| Esther Edery M.D. | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | |
| Burial | | 4/28/67 | | Lake View Cemetery | |
| 24D. LOCATION (City, town, or county) (State) | | Liberty Rd. Carroll Co. Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| MAY 2 1967 | | R. E. Farley, M.D. | | Loring Byers-8728 Liberty Rd. Randallstown | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|---|---------------------|--|---|
| BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 4277 | |
| BIRTH NO. -315 67 4277 | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 2. DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED
(Type or Print) <i>Stevens Edwin H.</i> | | <i>4-27-67</i> <i>5 55 P.</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<i>34 Bon Secours Hosp.</i> | | A. STATE <i>Maryland</i>
B. COUNTY <i>Hanford Co.</i> | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<i>Aberdeen</i> | |
| | | D. STREET ADDRESS (If rural, give location)
<i>136 Osborn Road</i> | |
| 5. SEX
<i>M</i> | 6. RACE
<i>W</i> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<i>Widowed</i> | 8. DATE OF BIRTH
<i>11-11-93</i> |
| | | 9. AGE (In years last birthday)
<i>73</i> | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Attorney</i> |
| | | 11. BIRTHPLACE (State or foreign country)
<i>Maryland</i> | 12. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> |
| 13. FATHER'S NAME
<i>Joseph Stevens</i> | | 14. MOTHER'S MAIDEN NAME
<i>Annie E. Parlett</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>No</i> | | 16. SOCIAL SECURITY NO.
<i>213-38-9904</i> | |
| | | 17. INFORMANT ADDRESS
<i>Marie Messina, Baltimore, Md.</i> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
<i>Pulmonary edema ? less due to carcinoma of throat 1 year the lung & metastasis</i> | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
<i>- Brain Metastasis?</i> | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION
<i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED | |
| | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>3/24</i> 19 <i>67</i> to <i>4/27</i> 19 <i>67</i> . | | | |
| that (I) (we) last saw the deceased alive on <i>4/27</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE
<i>AH. Ghiladi</i> M.D. | | 23B. DATE SIGNED
<i>4/27/67</i> | |
| 23C. PHYSICIAN'S NAME (Type)
<i>Abdolhamid Ghiladi</i> M.D. | | 23D. ADDRESS
<i>Bon Secours Hospital</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 24B. DATE
<i>1 May 67</i> | |
| 24C. NAME OF CEMETERY or CREMATORY
<i>St Paul Lutheran Cem.</i> | | 24D. LOCATION (City, town, or county) (State)
<i>Aberdeen, (Hanford) Md.</i> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<i>MAY 2 1967</i> | | 25B. NAME OF REGISTRAR
<i>Robert E. Tarkenton</i> | |
| | | 25C. FUNERAL HOME ADDRESS
<i>Tarkenton Funeral Home, Aberdeen, Md.</i> | |

28

Robertson
H. H. H.

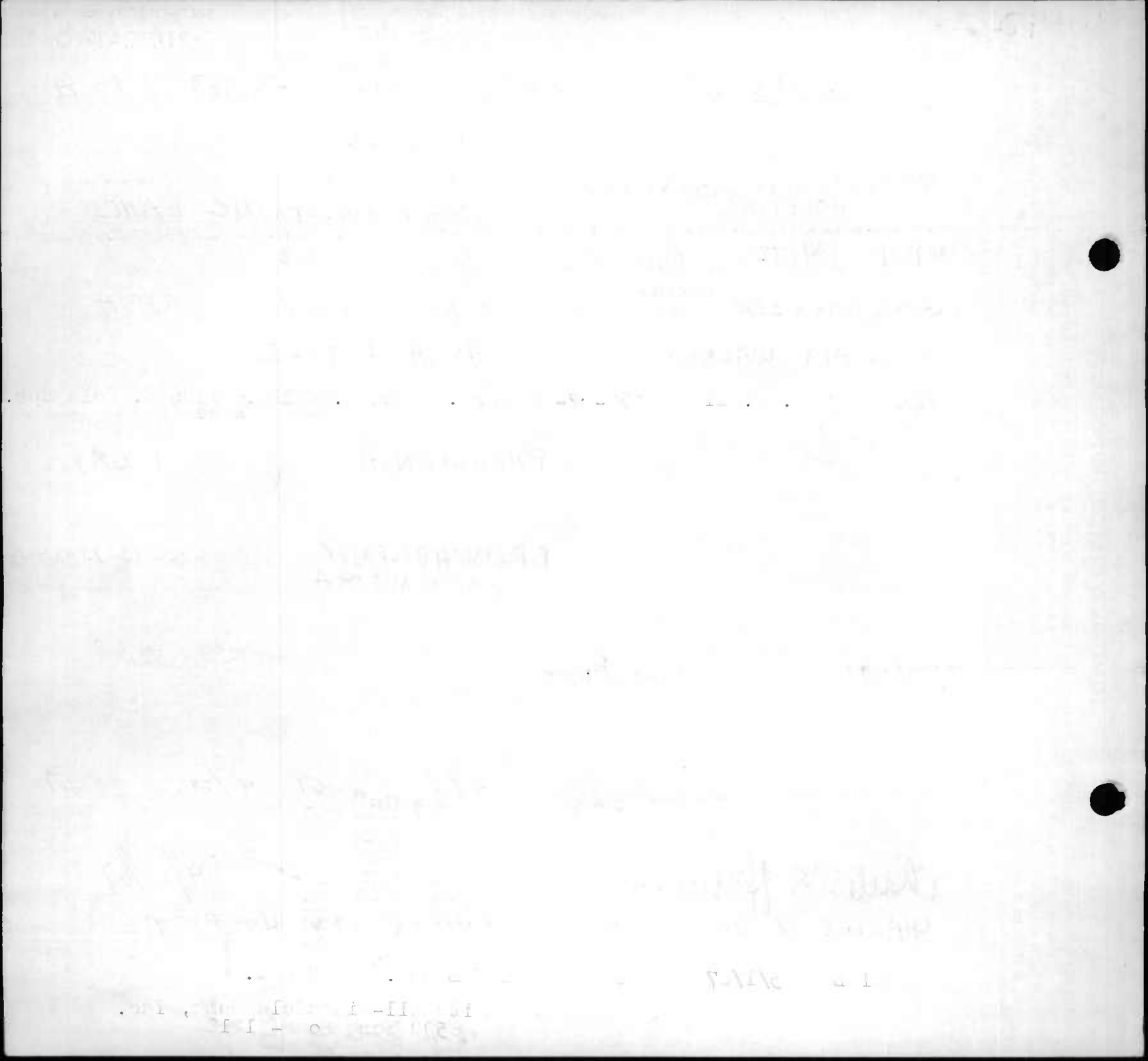
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 4278 | |
|---|---------|--|------------------|--|------------------------------|
| BIRTH NO. 67 4278 | | | | | |
| CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) | |
| | | | | WALKER DON FRED | |
| 2. DATE AND HOUR OF DEATH | | APRIL 28 1967 1:15 A M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived; if institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE B. COUNTY | | | |
| UNIVERSITY OF MARYLAND 38 HOSPITAL | | MARYLAND | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| | | BALTIMORE 27-09 | | | |
| | | D. STREET ADDRESS (If rural, give location) | | | |
| | | 1306 E. COLDSPRING LANE | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. CITIZEN OF WHAT COUNTRY? |
| MALE | WHITE | MARRIED | 10/29/13 | 53 | USA |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| CLAIMS AUTHORIZER | | SOCIAL SECURITY | | PENNSYLVANIA | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | |
| WILLIAM WALKER | | ANNA LITTLE | | YES ? W. W. II | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| 171-07-2768 | | Mrs. Agnes H. Walker | | 1306 E. Cold Spr. Lane | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) | | (A) PNEUMONIA | | 1 DAY | |
| ANTECEDENT CAUSES | | (B) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) BRONCHOGENIC CARCINOMA | | 6-12 MONTHS | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 4/19/67 | | DIAGNOSIS | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 4/14 1967 to 4/28 1967, that (I) (we) last saw the deceased alive on 4/27 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | 23B. DATE SIGNED | | | |
| Charles M. Harrison | | 4/28/67 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| CHARLES M. HARRISON | | UNIVERSITY HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| BURIAL | | 5/1/67 | | BALTIMORE NATIONAL CEM. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| MAY 2 1967 | | Poly E. Farber | | Mitchell-Wiedefeld Home, Inc. | |
| | | | | 4650 York Road-21212 | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-530

67 4279

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 67 4279

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Kent, Gretchen D.

2. DATE AND HOUR OF DEATH

4/28/67

4:30 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION

(If not in hospital or institution, give street address or location)

George Washington Nursing Home
607 Pennsylvania Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

MD.
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE

D. STREET ADDRESS (If rural, give location)
221 Fremont Ave.

5. SEX

Female Negro

6. RACE

7. MARRIED, NEVER MARRIED
(WIDOWED) DIVORCED (specify)

8. DATE OF BIRTH

1884

9. AGE (In years lost birthday)

82

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Domestic Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

John Berry

14. MOTHER'S MAIDEN NAME

Alethia Boone

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Chart + Son

ADDRESS

1600 N. FULTON AVE.
Balt. Md. 17

18. 331 X I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) DUE TO

Pericardial Extension

1958

(B) DUE TO

CVA

1960

(C) DUE TO

C I F.

3 days

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11-3-66 to 4/28-1967, that (I) (we) last saw the deceased alive on 4/27-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

E E Hall

M.D.

Attending Phys. ☒

Med. Director ☐

Staff Phys. ☐

23B. DATE SIGNED

4/18/67

23C. PHYSICIAN'S NAME (Type)

E E Hall

M.D.

23D. ADDRESS

3715 Liberty Heights Ave. Balt. Md.

24A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

5/1/67

24C. NAME OF CEMETERY or CREMATORY

Young's Methodist

24D. LOCATION

HUNTINGTOWN - MD

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

MAY 2 1967

25B. NAME OF REGISTRAR

Robert E. Finkbeiner

25C. FUNERAL DIRECTOR

Jerome F. Berry - HUNTINGTOWN MD

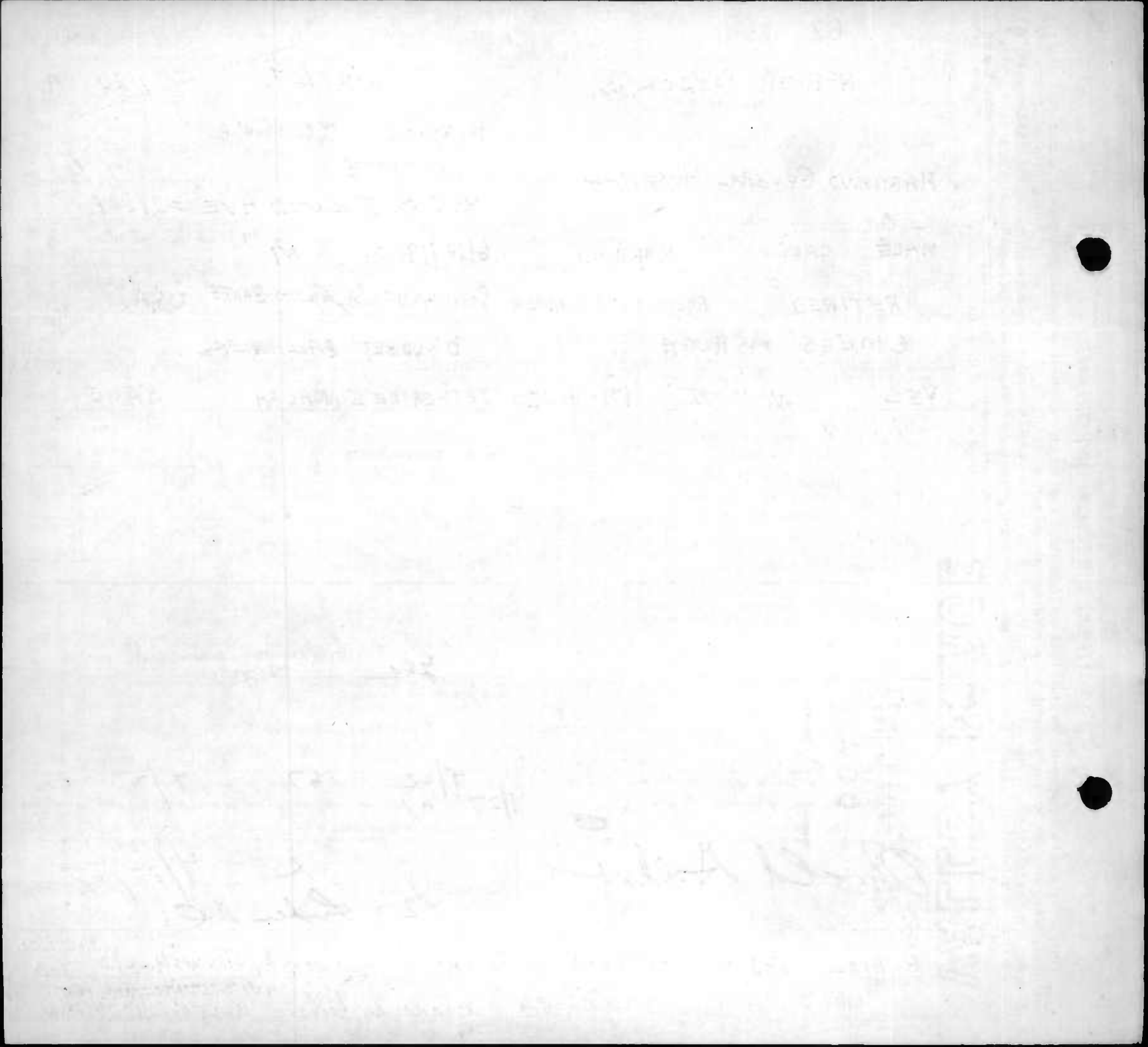
ADDRESS

1955

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|-------------------------|--|---------------------------------------|--|---|
| BIRTH NO. 67 4280 | | CITY HEALTH DEPARTMENT | | Registered No. 67 4280 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) McHUGH, PATRICK, J. | | 2. DATE AND HOUR OF DEATH
4/27/67. 4:20 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY BALTIMORE
C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE
D. STREET ADDRESS (If rural, give location) 835 S. ELLWOOD AVE. #21224 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
MARYLAND GENERAL HOSPITAL | | | | | |
| 5. SEX
MALE | 6. RACE
CAUC. | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
MARRIED | 8. DATE OF BIRTH
6/14/1900. | 9. AGE (In years last birthday)
67 | 10. Under 1 Yr. Months Days
11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
RETIRED | | 10B. KIND OF BUSINESS OR INDUSTRY
BALTO. CITY WORKER | | 11. BIRTHPLACE (State or foreign country)
PENNSYLVANIA, WILKES BARRE | |
| 12. CITIZEN OF WHAT COUNTRY?
USA. | | | | | |
| 13. FATHER'S NAME
CHARLES MCHUGH | | 14. MOTHER'S MAIDEN NAME
BRIDGET GALLAGHER | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
YES W. W. II | | 16. SOCIAL SECURITY NO.
179-14-1220 | | 17. INFORMANT
CATHERINE E MCHUGH | |
| 18. ADDRESS
SAME | | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
1638 I
BRONCHOPNEUMONIA
AGE | | CAUSE OF DEATH
(A) DUE TO
(B) DUE TO
(C) | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
yes | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
yes | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 4/22 19 67 to 4/27 19 67 that (I) (we) last saw the deceased alive on 4/27 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Ronald Goldner | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
4/27/67 | |
| 23C. PHYSICIAN'S NAME (Type)
RONALD GOLDNER | | 23D. ADDRESS
827 Linden Ave | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
5-1-67 | | 24C. NAME OF CEMETERY or CREMATORY
GARDENS OF FAITH | |
| 24D. LOCATION (City, town, or county)
KENWOOD AV. & TRUMPS MILL RD BALTO. CO., MD. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 2 1967 | | 25B. NAME OF REGISTRAR
Robert E. Taylor | | 25C. FUNERAL DIRECTOR
Charles J. Gailer | |
| ADDRESS
901 S. CONKLING ST. BALTO., 21224, MD. | | | | | |



1
I-240

| BIRTH NO. 67 4281 | | BALTIMORE CITY HEALTH DEPARTMENT | | 67 4281 | |
|--|---------|---|------------------|--|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. | | | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR PRONOUNCED DEAD | |
| | | VIVIAN INEZ ISLEY | | April 27, 1967 12:50 A M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | A. STATE Maryland | | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | B. COUNTY | | | |
| 00 2632 Boone Street | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) | | | |
| | | Baltimore | | | |
| | | D. STREET ADDRESS (If rural, give location) | | | |
| | | 2632 Boone Street | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. Under 1 Yr. 11 Under 24 Hrs. Months, Days, Hours, Min. |
| Female | Negro | married | Apr 21 - 1915 | 52 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Housewife | | | | Washington D.C. | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| Joseph Johnston | | Lola Johnston | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| | | | | Lorraine Isley 2632 Boone St | |
| 18. 422.1 I | | CAUSE OF DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | (A) Arteriosclerotic Cardiovascular Disease. | | | |
| (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | DUE TO | | | |
| ANTECEDENT CAUSES | | (B) DUE TO | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (C) DUE TO | | | |
| II | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 0 | | | | No | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| (Month) (Day) (Year) (Hour) | | WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | |
| 22. | | I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE | | CHIEF MEDICAL EXAMINER | | DATE SIGNED | |
| EXAMINER'S NAME (Type) | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 4/27/67 | |
| Charles S. Petty | | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) | | 23B. DATE | | 23C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 5-1-67 | | Mt Auburn Em Balto | |
| 24A. DATE REC'D BY HEALTH DEPT. | | 24B. NAME OF REGISTRAR | | 24C. FUNERAL DIRECTOR ADDRESS | |
| MAY 2 1967 | | Robert E. Fisk | | Rayner Sanders 217 E. Preston St | |

19670004289

THE JOURNAL OF THE

AMERICAN MEDICAL ASSOCIATION

PUBLISHED WEEKLY

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributory cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 4282 | |
|--|-----------|---|------------------|--|---|
| BIRTH NO. 67 4282 | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | Mrs. Rose E. Lacomare | | April 28, 1967 8:05 A. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE B. COUNTY | | | |
| FULL NAME OF INSTITUTION (If not in hospital or institution, give street address or location) | | Md. | | | |
| Union Memorial Hospital | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | Baltimore 9-05 | |
| | | D. STREET ADDRESS (If rural, give location) | | 807 Homestead St. | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| Female | Caucasian | Divorced | 8/14/00 | 66 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| None | | Unknown | | Maryland | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| Joseph Maruono | | Concetta | | U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| No | | | | Mr John Lacomare Unknown | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| 465 X I | | (A) Recent infant, ant. wall left ventricle | | | |
| ANTECEDENT CAUSES | | (B) Pulmonary embolism to major branch of right lung. M. Newman | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 2 | | | | Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | YES | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | |
| 22. I certify that (H) (this hospital) attended the deceased from 3/8/67 19 67 to 4/28 19 67, that (H) (we) last saw the deceased alive on 4/27 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| Nat E. Watson, Jr. | | | | 4/28/67 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| NAT E. WATSON, JR. | | | | THE UNION MEMORIAL HOSPITAL | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 5/1/67 | | Meadowridge Cemetery | |
| | | | | Dorsey, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| MAY 2 1967 | | R. E. E. F. F. F. | | Ambrose Tr. 1328 Sulphur Sp Rd | |

Mr. John F. ...

Union Memorial Hospital
Female Cancerous Ovaries
Mrs. Joseph Morrison
Unknown

Mr. John Morrison
Concetta
Maryland
8/4/02
807 Humboldt St.
Baltimore

Yes

4/2/01 4/2/01 4/2/01

late history of

THE ... AL HOSPITAL

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REGISTERED NO. 67 4283 | |
|---|------------------|--|----------------------------|--|--|
| CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. 10 67 4283 | | M.E. CASE NO. | | | |
| 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| NEIGHOFF, SR. WILLIAM P. | | 4-30-67 | | 9:15 P. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION

40 ST. AGNES HOSPITAL | | A. STATE MARYLAND
B. COUNTY ANNE ARUNDEL Co. | | | |
| (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
PASADENA 21122 52-00 | | | |
| | | D. STREET ADDRESS (If rural, give location)
611 RIVERSIDE DRIVE (Chelsee Beach) | | | |
| 5. SEX
MALE | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
MARRIED | 8. DATE OF BIRTH
1-3-99 | 9. AGE (In years
last birthday)
68 | 10. Under 1 Yr.
Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
CONTRACTOR | | 10B. KIND OF BUSINESS OR INDUSTRY
Self-Employed | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
DAVID NEIGHOFF | | | |
| 14. MOTHER'S MAIDEN NAME
Catherine Yeager | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO None | | | |
| 16. SOCIAL SECURITY NO.
216 09 6907 | | 17. INFORMANT ADDRESS
ST. AGNES RECORDS-CATON & WILKENS AVES | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

420.0 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) DUE TO
Father's aortic heart disease.
(B) DUE TO
Caplet A-V Block
(C) DUE TO
Adams Stokes | | INTERVAL BETWEEN ONSET AND DEATH

Mm | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from APRIL 28 19 67 to APRIL 30 19 67, that (I) (we) last saw the deceased alive on APRIL 30 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Dr. Georgi Angov | | 23B. DATE SIGNED
5-1-67 | | 23C. PHYSICIAN'S NAME (Type)
DR. GEORGI ANGOV | |
| 23D. ADDRESS
ST. AGNES HOSPITAL, WILKENS & CATON AVE. | | 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | | |
| 24B. DATE
May 4, 1967 | | 24C. NAME OF CEMETERY or CREMATORY
Glen Haven Memorial Park | | 24D. LOCATION (City, town, or county) (State)
Glen Burnie, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 2 1967 | | 25B. NAME OF REGISTRAR
Robert E. Taylor | | 25C. FUNERAL DIRECTOR
Richard V. Singleton | |
| | | | | ADDRESS
Geln Burnie, Md. | |

2:15P

4-10-41

11:11A

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|--|--------------------------------|---|---|
| <p>BIRTH NO. 67 4284</p> <p>CERTIFICATE OF DEATH</p> <p>Registered No. 67 4284</p> | | | |
| <p>M.E. CASE NO.</p> <p>1. NAME OF DECEASED (Type or print) <u>CHRISTIAN N. FEICK</u></p> | | <p>2. DATE AND HOUR OF DEATH</p> <p><u>4/29/67</u> <u>2:30 P</u> M.</p> | |
| <p>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</p> <p>CERTIFICATE AMENDED</p> <p>FULL NAME OF (If not in hospital or institution, give street address or location) <u>FRANKLIN SQUARE HOSP.</u></p> | | <p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</p> <p>A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u></p> <p>C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u></p> <p>D. STREET ADDRESS (If rural, give location) <u>6218 24 W. LOMBARD ST.</u></p> | |
| <p>5. SEX <u>M</u></p> | <p>6. RACE <u>W</u></p> | <p>7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)</p> | <p>8. DATE OF BIRTH <u>6/25/1893</u></p> |
| <p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u></p> | | <p>10B. KIND OF BUSINESS OR INDUSTRY <u>CIVIL SER USCG</u></p> | |
| <p>11. BIRTHPLACE (State or foreign country) <u>BALTIMORE</u></p> | | <p>12. CITIZEN OF WHAT COUNTRY? <u>USA</u></p> | |
| <p>13. FATHER'S NAME <u>FEICK, CHRISTIAN</u></p> | | <p>14. MOTHER'S MAIDEN NAME <u>ROSETTA RUEGG</u></p> | |
| <p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES</u> <u>WWI</u></p> | | <p>16. SOCIAL SECURITY NO. <u>215-03-7812</u></p> | |
| <p>17. INFORMANT <u>MRS. FEICK</u></p> | | <p>ADDRESS <u>SAME</u></p> | |
| <p>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)</p> <p><u>350 XI</u></p> | | <p>CAUSE OF DEATH</p> <p>(A) <u>CEREBRO-VASCULAR INSUFFICIENCY</u></p> <p>(B) <u>GENERALIZED ARTERIOSCLEROSIS</u></p> <p>(C) <u>PARKINSONISM</u></p> | |
| <p>INTERVAL BETWEEN ONSET AND DEATH</p> | | <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.</p> | |
| <p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p> <p><u>DEHYDRATION - ELECTROLYTE IMBALANCE</u></p> | | | |
| <p>19A. DATE OF OPERATION <u>0</u></p> | | <p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p> | |
| <p>20A. AUTOPSY? (Yes or No)</p> | | <p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p> | |
| <p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p> | | <p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p> | |
| <p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p> | | <p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour)</p> | |
| <p>21E. INJURY OCCURRED</p> <p>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p> | | <p>21F. HOW DID INJURY OCCUR?</p> | |
| <p>22. I certify that (I) (this hospital) attended the deceased from <u>4/17</u> <u>19 67</u> to <u>4/29</u> <u>19 67</u>.</p> <p>that (I) (we) lost saw the deceased alive on <u>4/29</u> <u>19 67</u> and that in (my) (our) opinion death occurred on the date <u>4/29</u> <u>19 67</u>.</p> <p>and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p> | | | |
| <p>23A. SIGNATURE <u>Milagro R. Calizo</u></p> | | <p>23B. DATE SIGNED <u>4/29/67</u></p> | |
| <p>23C. PHYSICIAN'S NAME (Type) <u>MILAGROSA R. CALIZO</u></p> | | <p>23D. ADDRESS <u>FRANKLIN SQUARE HOSP.</u></p> | |
| <p>24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u></p> | | <p>24B. DATE <u>May 2, 1967</u></p> | |
| <p>24C. NAME OF CEMETERY or CREMATORY <u>Western Cemetery</u></p> | | <p>24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u></p> | |
| <p>25A. DATE REC'D BY HEALTH DEPT. <u>MAY 2 1967</u></p> | | <p>25B. NAME OF REGISTRAR <u>Robert E. Taylor</u></p> | |
| <p>25C. FUNERAL DIRECTOR <u>Sterling Funeral Estate</u></p> | | <p>ADDRESS <u>736 Edmondson Av., Catonsville, Md</u></p> | |

V. 2. 153

5-8-67

M.H.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 4285 | |
|---|---------------------------|--|--|--|---|
| BIRTH NO. 67 4285 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) William G. Young | | 2. DATE AND HOUR OF DEATH
April 27, 1967 9:00 P. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore 16-07 | |
| FULL NAME OF HOSPITAL OR INSTITUTION
3035 Presstman St. | | D. STREET ADDRESS (If rural, give location)
3035 Presstman St. | | E. AGE (In years last birthday) 77 | |
| 5. SEX
Male | 6. RACE
Colored | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widowed | 8. DATE OF BIRTH
Oct 8, 1889 | 9. AGE (In years last birthday) | 10. CITIZEN OF WHAT COUNTRY?
U. S. A. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Post-Office Ret. | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 13. FATHER'S NAME
William G. Young | | 14. MOTHER'S MAIDEN NAME
Harriett Young | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | |
| 16. SOCIAL SECURITY NO.
214-38-8647 | | 17. INFORMANT
Mrs. Hortense Y. Marshall | | ADDRESS 1152 N. Carey St | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
420.0 + 260X | | CAUSE OF DEATH
(A) <i>Arteriosclerotic Heart Disease</i>
DUE TO | | INTERVAL BETWEEN ONSET AND DEATH
<i>6 years</i> | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO | | | |
| (C) DUE TO | | | | | |
| II | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | <i>Diabetes Mellitus + Pyelonephritis</i> 40 yrs | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>August</i> 19 <i>61</i> to <i>April 27</i> 19 <i>67</i> , that (I) was last saw the deceased alive on <i>April 5</i> 19 <i>67</i> and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) we (did) did not view the body after death. | | | | | |
| 23A. SIGNATURE
<i>Roland T. Smoot</i> | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
<i>4/28/67</i> | |
| 23C. PHYSICIAN'S NAME (Type)
ROLAND T. SMOOT | | 23D. ADDRESS
M.D. 3817 COPLEY RD., BALTO. 15, MD. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
5-1-67 | | 24C. NAME OF CEMETERY or CREMATORY
Arbutus Mem. Park. | |
| 24D. LOCATION (City, town, or county) (State)
Arbutus, Balto., CO. Md. | | 25A. DATE REC'D BY HEALTH DEPT.
MAY 2 1967 | | 25B. NAME OF REGISTRAR
<i>Robert E. Johnson</i> | |
| 25C. FUNERAL DIRECTOR
<i>Mr. Francis A. Hemlock</i> | | 25D. ADDRESS
578 W. Biddle St. | | | |

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1941, 10, 11

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | |
|--|-------------------------|--|--|--|--|---|--|--|--|---|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| BIRTH NO. | | 67 4286 | | Registered No. | | | | 67 4286 | | | |
| M.E. CASE NO. | | | | | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) NEWMAN, PATRICK J. | | | | | | 2. DATE AND HOUR OF DEATH
APRIL 29, 1967 8:55 P. M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
ST. AGNES HOSPITAL
WILKENS & CATON AVENUE
BALTIMORE, MARYLAND 21229 | | | | | | A. STATE MARYLAND B. COUNTY 21227 | | | | | |
| | | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE | | | | | |
| D. STREET ADDRESS (If rural, give location)
1226 POPLAR AVENUE | | | | | | Balto. Co 53-00 | | | | | |
| 5. SEX
MALE | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
MARRIED | | 8. DATE OF BIRTH
02/28/19 | | 9. AGE (In years lost birthday)
48 | | 10. Under 1 Yr. Months: Days: Hours: Min. | | 11. Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
POLICEMAN | | | | 10B. KIND OF BUSINESS OR INDUSTRY
DEPT. BALTO. CITY POLICE | | | | 11. BIRTHPLACE (State or foreign country)
MASSACHUSETTS | | | |
| 12. CITIZEN OF WHAT COUNTRY? | | | | | | | | | | | |
| 13. FATHER'S NAME
MORRIS (DECEASED) | | | | | | 14. MOTHER'S MAIDEN NAME
KATHERINE, DONOVAN (DECEASED) | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
YES WORLD WAR II | | | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
ST. AGNES HOSPITAL
WILKENS & CATON AVE, BALTO., MD 21229 | | | |
| 18. CAUSE OF DEATH | | | | | | | | | | | |
| <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> </div> <div style="width: 50%;"> <p>CAUSE OF DEATH</p> <p>(A) <i>Carcinoma, Recto sigmoid - colon with metastases to periaortic gland and the root</i></p> <p>(B) <i>of the mesenteric and</i></p> <p>(C) <i>metastases to the liver</i></p> </div> </div> | | | | | | | | | | | |
| <p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p> | | | | | | | | | | | |
| MEDICAL CERTIFICATION | | | | | | | | | | | |
| 19A. DATE OF OPERATION | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20A. AUTOPSY? (Yes or No)
NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | 21F. HOW DID INJURY OCCUR? | | | |
| <p>22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from APRIL 18 1967 to APRIL 29 1967, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on APRIL 29, 1967 and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) <input checked="" type="checkbox"/> (did not) view the body after death.</p> | | | | | | | | | | | |
| 23A. SIGNATURE
<i>Paulino O. Vasallo</i> | | | | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
<i>April 29-67</i> | |
| 23C. PHYSICIAN'S NAME (Type)
<i>Paulino O. Vasallo</i> | | | | | | | | 23D. ADDRESS
M.D. <i>608 Markham Rd. Balto. Md. 21229</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | | | 24B. DATE
5/3/67 | | 24C. NAME of CEMETERY or CREMATORY
Baltimore National Cemetery | | | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 2 1967 | | | | 25B. NAME OF REGISTRAR
<i>Robert E. Talley</i> | | | | 25C. FUNERAL DIRECTOR ADDRESS
Howard H. Hubbard 4107 Wilkens Ave. 21229 | | | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 4287 | |
|---|-------------------------|--|--|--|---|
| BIRTH NO. 67 4287 | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED
(Type or Print) ELIZABETH J. LENZ | | | 2. DATE AND HOUR OF DEATH
April 28, 1967 | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

1001 Haverhill Rd. | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE Md.
B. COUNTY

C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
1001 Haverhill Rd. | | |
| 5. SEX
Female | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widowed | 8. DATE OF BIRTH
11/8/86 | 9. AGE (In years last birthday)
80 | If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired housewife | | | 11. BIRTHPLACE (State or foreign country)
Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. |
| 13. FATHER'S NAME
August Schroeder | | | 14. MOTHER'S MAIDEN NAME
Justine Knopper | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 17. INFORMANT Bullinger Easton, Md. 21601
George R. Bullinger 513 N. Washington St. | | |
| 16. SOCIAL SECURITY NO.
None | | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
420.1 I
Coronary occlusion
ISCVD | | | CAUSE OF DEATH
(A) DUE TO
(B) DUE TO
(C) DUE TO | | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | INTERVAL BETWEEN ONSET AND DEATH
4-27-67
3 | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 6-23-67 to 4-28-67 that (I) (we) last saw the deceased alive on 6-20-67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Earl I. Pass M.D. | | | | 23B. DATE SIGNED
4-28-67 | |
| 23C. PHYSICIAN'S NAME (Type)
Dr. Earl I. Pass | | | | 23D. ADDRESS
4001 Wilkens Ave | |
| 24A. BURIAL CREMATION, REMOVAL
Burial | | 24B. DATE
XXXXXX | | 24C. NAME OF CEMETERY OR CREMATORY
Loudon Park Cemetery | |
| 24D. LOCATION (City, town, or county) (State)
Baltimore, Md. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 2 1967 | | 25B. NAME OF REGISTRAR
Robert E. Johnson | | 25C. FUNERAL DIRECTOR
Howard H. Hubbard | |
| | | | | ADDRESS
4107 Wilkens Ave. | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 4288 | |
|---|-------------------------|--|--|--|---|
| BIRTH NO. 67 4288 | | M.E. CASE NO. | | | |
| 1. NAME OF DECEASED
(Type or Print) HATTIE O. BECK | | | 2. DATE AND HOUR OF DEATH
April 26, 1967 | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

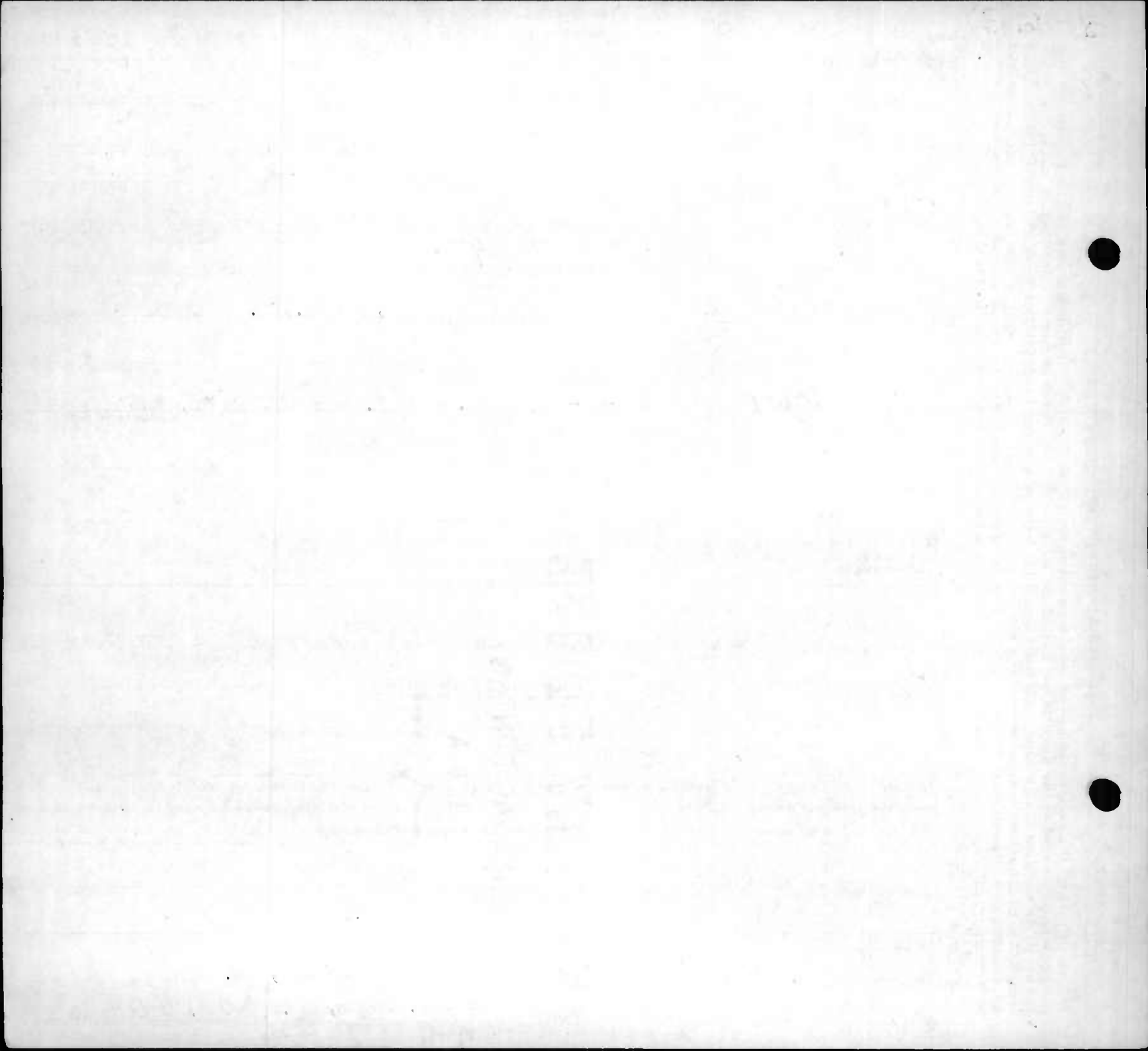
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
00 2004 Breitwert Avenue
Baltimore, Maryland | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Baltimore
C. CITY OR TOWN (If outside city limits, write RURAL and give township) 25-43
D. STREET ADDRESS (If rural, give location)
2004 Breitwert Avenue | | |
| 5. SEX
Female | 6. RACE
White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
Married | 8. DATE OF BIRTH
6-26-1888 | 9. AGE (In years last birthday)
78 Yrs. | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country)
Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. |
| 13. FATHER'S NAME
William Potee | | | 14. MOTHER'S MAIDEN NAME
Elsie McClintock | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
216-09-6535B | 17. INFORMANT ADDRESS
Mr. John O. Beck, 2004 Breitwert Ave. 21230 | | |
| 18. 450.0 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Arteriosclerosis, generalized
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | CAUSE OF DEATH
Arteriosclerosis, generalized
INTERVAL BETWEEN ONSET AND DEATH
6 yrs. | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that (I) (the hospital) attended the deceased from 6/19/54 19 to 4/26/67 19, that (I) (we) last saw the deceased alive on 4/26/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
C. Arthur Rossberg M.D. | | | 23B. DATE SIGNED
4/28/67 | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> |
| 23C. PHYSICIAN'S NAME (Type)
Dr. C. Arthur Rossberg | | | 23D. ADDRESS
2436 Washington Boulevard, Balto., Md. | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
5-1-1967 | 24C. NAME OF CEMETERY or CREMATORY
Meadowridge Cemetery | | 24D. LOCATION (City, town, or county) (State)
Howard County, Maryland |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 2 1967 | | 25B. NAME OF REGISTRAR
Robert E. Taylor | | 25C. FUNERAL DIRECTOR ADDRESS
Howard H. Hubbard, 4107 Wilkens Avenue | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|--------------------------------|--|---|---|---|--|--|---|--|
| CERTIFICATE OF DEATH | | | | | Registered No. 67 4289 | | | | |
| BIRTH NO. 67 4289
M.E. CASE NO.
1. NAME OF DECEASED (Type or Print) WILLIAM T GARRETT | | | | | 2. DATE AND HOUR OF DEATH
MAY 1 67 11 35 A.M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
48 MARYLAND GENERAL HOSP | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE
D. STREET ADDRESS (If rural, give location)
253 S. ROBINSON ST. | | | | |
| 5. SEX
M | 6. RACE
CAUC. | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married | | 8. DATE OF BIRTH
9-25-96 | 9. AGE (In years last birthday)
70 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Boiler maker (retired) | 11. BIRTHPLACE (State or foreign country)
USA Balto., Md. | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
THOMAS GARRETT | | | | | 14. MOTHER'S MAIDEN NAME
FLORENCE WINDER | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
yes WWI | | | | | 16. SOCIAL SECURITY NO.
212-03-4975A | | 17. INFORMANT Mrs. Mary M. Garrett, 253 S. Robinson St | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osteoma, etc. It means the disease, injury or complication which caused death.)
332 XI
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | CAUSE OF DEATH
(A) DUE TO Cerebrovascular thrombosis 2 weeks
(B) DUE TO Hypertension, idiopathic Unknown
(C) DUE TO | | | | |
| 19A. DATE OF OPERATION
0 | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
No | | 20A. AUTOPSY? (Yes or No)
No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
No |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
No | | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
No | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
No | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)
No | | | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR?
No | | |
| 22. I certify that (I) (this hospital) attended the deceased from 4/22 1967 to 5/1 1967, that (I) (we) last saw the deceased alive on 5/1 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
Timothy Kenney Gray | | | | | M.D. <input type="checkbox"/> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
5/1/67 | | |
| 23C. PHYSICIAN'S NAME (Type)
TIMOTHY KENNEY GRAY | | | | | 23D. ADDRESS
MARYLAND GENERAL HOSP | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
5/4/67 | | 24C. NAME of CEMETERY or CREMATORY
Oak Lawn Cemetery | | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Md. | | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 2 1967 | | | 25B. NAME OF REGISTRAR
John A. Moran, Inc. | | | 25C. FUNERAL DIRECTOR 3000 E. Baltimore St | | | |



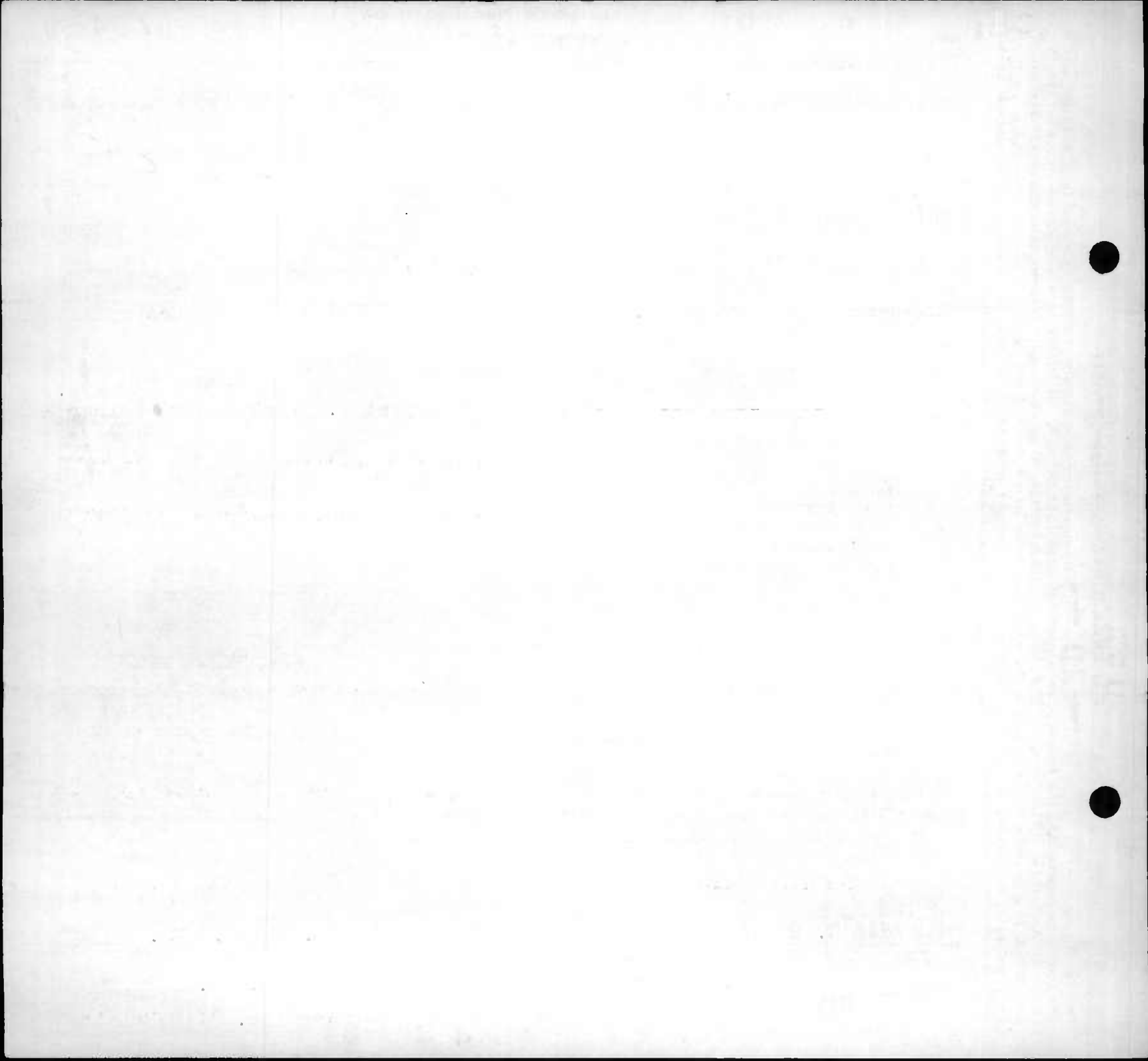
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 4290 | |
|--|--|---|--|---|--|
| BIRTH NO. 67 4290 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) Francis X. Bracken | | | |
| 2. DATE AND HOUR OF DEATH
April 30, 1967 1:30 P M. | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Union Memorial Hosp (DOA) | | | |
| 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE Maryland
B. COUNTY | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore 26-01 | | | |
| D. STREET ADDRESS (If rural, give location)
4220 Belmar Avenue | | 5. SEX Male 6. RACE Caucasian 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | | | |
| 8. DATE OF BIRTH June 11, 1894 9. AGE (In years last birthday) 72 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer 10B. KIND OF BUSINESS OR INDUSTRY Glen L. Martins | | | |
| 11. BIRTHPLACE (State or foreign country) Maine | | 12. CITIZEN OF WHAT COUNTRY? USA | | | |
| 13. FATHER'S NAME unknown | | 14. MOTHER'S MAIDEN NAME unknown | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO. 216-05-7585A | | 17. INFORMANT Margaret C. Bracken ADDRESS 4220 Belmar Ave. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Myocardial Infarction | | INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hours | | | |
| ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO Arteriosclerosis & Coronary Artery Disease 10 years | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No. | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from June 11 1944 to April 30 1967 , that (I) (we) last saw the deceased alive on March 17 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Adam G. Swiss | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED May 1, 1967 | |
| 23C. PHYSICIAN'S NAME (Type) Adam G. Swiss | | 23D. ADDRESS 6232 Belair Rd. Balto., Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE May 3, 1967 | | 24C. NAME OF CEMETERY or CREMATORY Parkwood Cemetery | |
| 24D. LOCATION (City, town, or county) Baltimore, Md. | | 24E. (State) | | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAY 2 1967 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR Dippel Brothers Inc. ADDRESS 7110 Belair Rd | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|---------------------|---|--|------------------------------------|--|---|--|------------------------------------|--|
| CERTIFICATE OF DEATH | | | | | Registered No. 67 4291 | | | | |
| BIRTH NO. 67 4291 | | M.E. CASE NO. | | | 2. DATE AND HOUR OF DEATH
April 28, 1967 2 A M. | | | | |
| 1. NAME OF DECEASED
(Type or Print) Nonn, Beverly Rose | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Florida
B. COUNTY | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
US Public Health Service Hospital
Wyman Pk. Drive & 31st Street | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Temple Terrace
D. STREET ADDRESS (If rural, give location)
5312 Temple Heights Road | | | | |
| 5. SEX
F | 6. RACE
W | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Single | | 8. DATE OF BIRTH
3/2/44 | 9. AGE (In years last birthday)
23 | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Secretary | | | 10B. KIND OF BUSINESS OR INDUSTRY
Singleton Shrimp Mfg. Co. | | 11. BIRTHPLACE (State or foreign country)
Wisc. | | 12. CITIZEN OF WHAT COUNTRY?
USA | | |
| 13. FATHER'S NAME
Clifford W. Nonn | | | | | 14. MOTHER'S MAIDEN NAME
Letha Pendleton | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
? | | | 16. SOCIAL SECURITY NO.
? | | 17. INFORMANT ADDRESS
Duvall Funeral Home, Tampa, Florida | | | | |
| 18. CAUSE OF DEATH
204.4 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Leukemia
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
pt dead on arrival at hospital | | | | | INTERVAL BETWEEN ONSET AND DEATH
? | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No)
no | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from DEAD ON ARRIVAL to 19 , that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
<i>Lewis M. Slater</i> | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | 23B. DATE SIGNED
4/28/67 | |
| 23C. PHYSICIAN'S NAME (Type)
Lewis M. Slater, Surgeon (R) | | | | | 23D. ADDRESS
M.D. US PHS Hospital, Balto, Md. | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Removal | | 24B. DATE
4/28/67 | | 24C. NAME of CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State)
Tampa, Fla. | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 2 1967 | | 25B. NAME OF REGISTRAR
<i>Robert E. Taylor</i> | | | 25C. FUNERAL DIRECTOR ADDRESS
Wm. Cook-Brooks Inc. Baltimore, Md. 21202 | | | | |

1. 2. 3.

1. 2. 3. 4. 5. 6. 7. 8. 9. 10.

1. 2. 3. 4. 5. 6. 7. 8. 9. 10.

1. 2. 3.

1. 2. 3. 4. 5. 6. 7. 8. 9. 10.

1. 2. 3.

1. 2. 3. 4. 5. 6. 7. 8. 9. 10.

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1. 2. 3. 4. 5. 6. 7. 8. 9. 10.

1. 2. 3. 4. 5. 6. 7. 8. 9. 10.

1. 2. 3. 4. 5. 6. 7. 8. 9. 10.

1. 2. 3.

1. 2. 3. 4. 5. 6. 7. 8. 9. 10.

1. 2. 3. 4. 5. 6. 7. 8. 9. 10.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 67 4292 | | CERTIFICATE OF DEATH | | Registered No. 67 4292 | |
|--|---------------------|--|------------------------------------|---|---|
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) FORREST, MRS BERTHA J. | | 2. DATE AND HOUR OF DEATH
5/1/67 7:10 AM | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
CHURCH HOME & HOSPITAL | | A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE
D. STREET ADDRESS (If rural, give location) 3218 Ramona Ave. (113) | | | |
| 5. SEX
F. | 6. RACE
W | 7. MARRIED NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married | 8. DATE OF BIRTH
6/22/90 | 9. AGE (In years last birthday)
76 | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
H/W | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
MD. | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
ARMIGER, Philip Peter Armiger | | | |
| 14. MOTHER'S MAIDEN NAME
UNKNOWN, Rose Lessner | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no, or unknown) (If yes, give war or dates of service)
No | | | |
| 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT ADDRESS
Mrs. Mary Perry, 3805 Ravenwood Ave. #13 | | | |
| 18. 260 X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | CAUSE OF DEATH
(A) DIABETES MELLITUS
DUE TO
(B) HYPERTENSIVE CVD
DUE TO
(C) CEREBRAL THROMBOSIS, recurrent. | | INTERVAL BETWEEN ONSET AND DEATH
OVER 10 YEARS
"
4 days | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
STATUS PNEUMONIA | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 4/28 19 67 to 5/1 19 67 , that (I) (we) last saw the deceased alive on 5/1 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
[Signature] | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
5/1/67 | |
| 23C. PHYSICIAN'S NAME (Type)
Dr. A.E. SUBONG, JR. | | 23D. ADDRESS
CHURCH HOME & HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
5/3/67 | | 24C. NAME OF CEMETERY OR CREMATORY
Holy Redeemer Cemetery | |
| 24D. LOCATION (City, town, or county) (State)
Baltimore, Md. | | 25A. DATE REC'D BY HEALTH DEPT.
MAY 2 1967 | | | |
| 25B. NAME OF REGISTRAR
Robert E. Farley | | 25C. FUNERAL DIRECTOR ADDRESS
Leonard J. Ruck, Inc. Balto. Md. 21214 | | | |

CHURCH HOME & HOSPITAL

F W

H/m

ARMED

3218 Franklin Ave. N.W.

6/20/21

M.D.

MINNESOTA

Diabetes Mellitus

Hypertensive CVD

Cerebral thrombosis
Recent

Status: Improved

2/1

4/5/21

2/1

2/1

~~Handwritten signature~~

CHURCH HOME & HOSPITAL

2/1/21

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

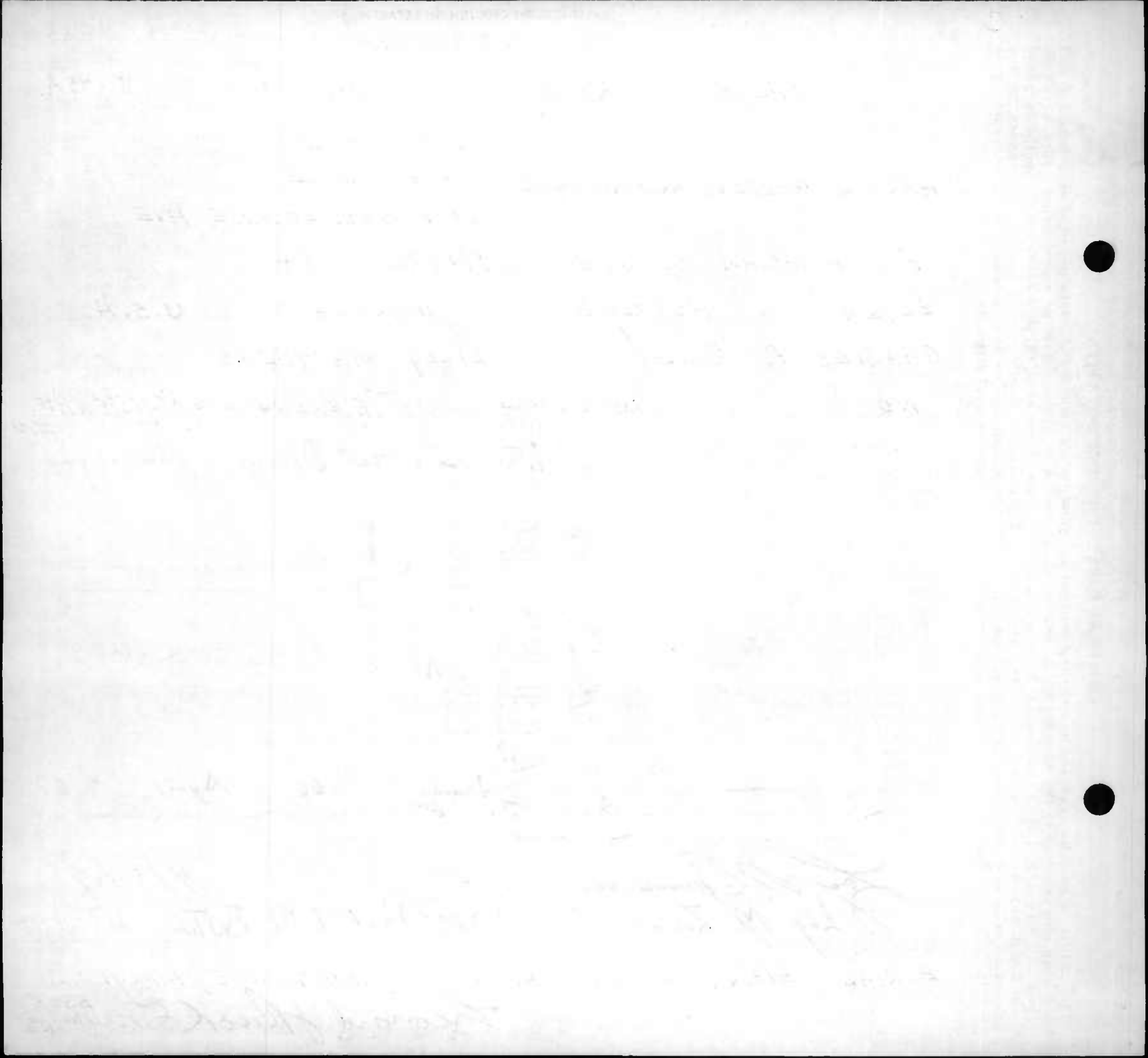
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 4293 | |
|--|-------------------------|---|--|---|---|
| TO BE CLEARED BY MEDICAL EXAMINER | | | | | |
| CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. 67 4293 | | M.E. CASE NO. 67 4293 | | | |
| 1. NAME OF DECEASED
(Type or Print) Agnes Winter | | | 2. DATE AND HOUR OF DEATH
4-29-67 5:00 P.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE Md. B. COUNTY | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
90 Bolton Hill Nursing Home | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE 9-06 | | |
| | | | D. STREET ADDRESS (If rural, give location)
2926 Hartford Rd. | | |
| 5. SEX
FEMALE | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Single | 8. DATE OF BIRTH
12-28-88 | 9. AGE (In years lost birthday)
79 | 10. If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
At Home | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 13. FATHER'S NAME
FRANK H. WINTER | | |
| 14. MOTHER'S MAIDEN NAME
MARY SHARPLEY | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | |
| 16. SOCIAL SECURITY NO.
None | | | 17. INFORMANT
MR. CHARLES WINTER-4611 MARBLE HALL RD. | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)
subcapital fracture left femur 3 weeks | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| 20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | A.S.C.V.D. | | |
| 21. DATE OF OPERATION | | | 22. CONDITION FOR WHICH OPERATION WAS PERFORMED | | |
| 23. DATE OF OPERATION | | | 24. AUTOPSY? (Yes or No)
No | | |
| 25. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 26. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 27. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
brothers house | | 28. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
4611 Marble Hall Road 27-09 | |
| 29. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour)
4 5 67 12:15 | | 30. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | 31. HOW DID INJURY OCCUR?
after coming down stairs, fell to floor | |
| 32. I certify that (He) (this hospital) attended the deceased from 4-25-67 19 to 4-29-67 19, that (I) (We) last saw the deceased alive on 4-29-67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 33. SIGNATURE
E. Ellsworth Cook M.D. | | | | 34. DATE SIGNED
4-29-67 | |
| 35. PHYSICIAN'S NAME (Type)
E. ELLSWORTH COOK | | | | 36. ADDRESS
2431 MARYLAND AVE. BALTO MD 21218 | |
| 37. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 38. DATE
5/2/67 | | 39. NAME OF CEMETERY or CREMATORY
NEW CATHEDRAL CEMETERY | |
| 40. LOCATION (City, town, or county) (State)
BALTIMORE, MD. | | 41. DATE REC'D BY HEALTH DEPT.
MAY 2 1967 | | | |
| 42. NAME OF REGISTRAR
Robert E. Taylor | | 43. FUNERAL DIRECTOR
LEONARD J. RUCK, INC. BALTO MD 21214 | | | |

Handwritten text, possibly a signature or initials, oriented vertically.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

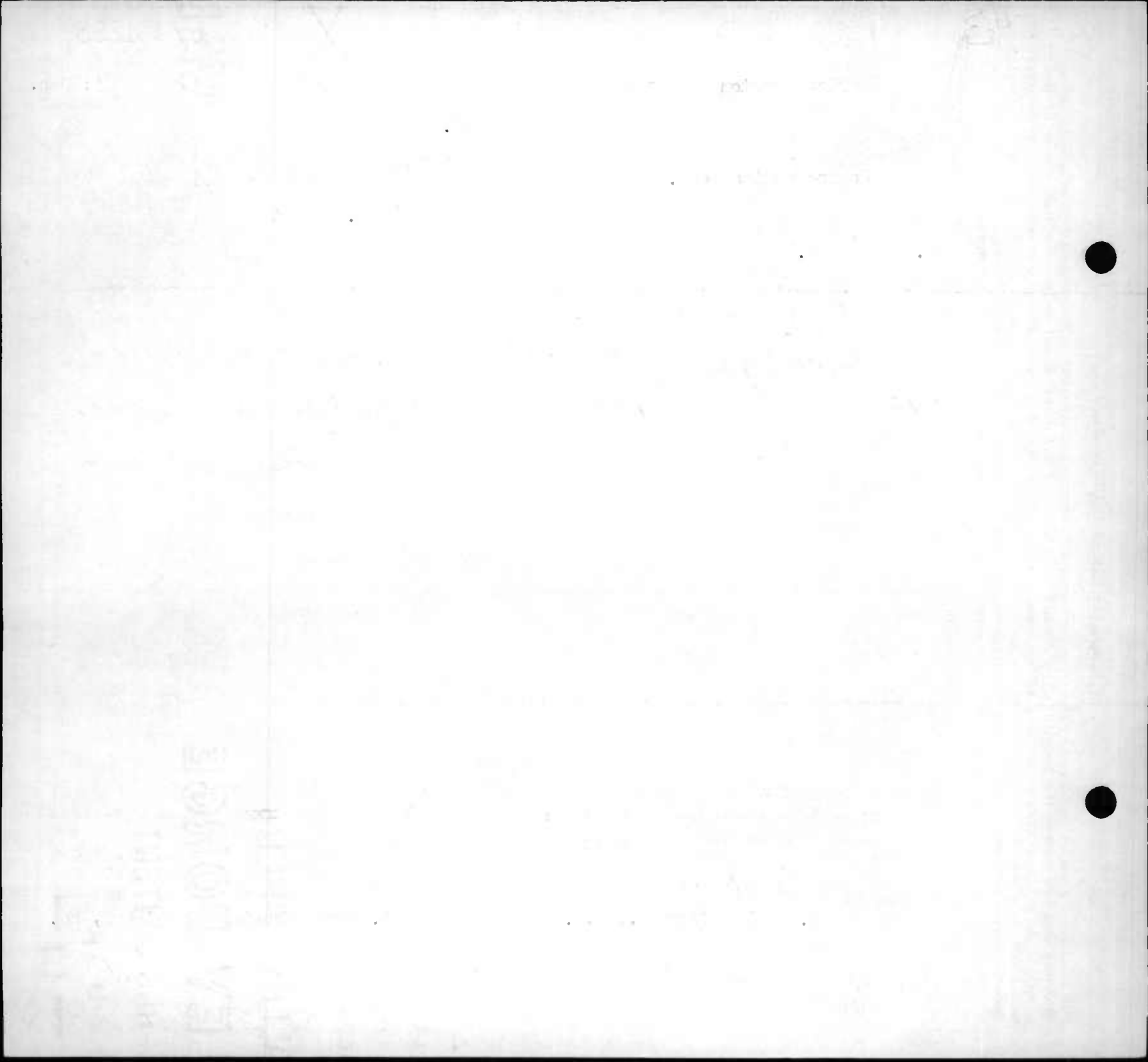
| BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 4294 | |
|--|--------------------------|---|--------------------------------|
| BIRTH NO. 67 4294 | | M.E. CASE NO. | |
| 1. NAME OF DECEASED (Type or Print) SADIE RILEY | | 2. DATE AND HOUR OF DEATH April 30, 1967 8:45 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 9 HARFORD GARDENS NURSING HOME | | A. STATE MARYLAND
B. COUNTY BALTIMORE | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | D. STREET ADDRESS (If rural, give location) 1917 WOODBOURNE AVE | |
| 5. SEX F | 6. RACE CAUCASIAN | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) SINGLE | 8. DATE OF BIRTH 9/1/82 |
| 9. AGE (In years last birthday) 84 | | 10. AGE (In years last birthday) 84 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BUYER | | 10B. KIND OF BUSINESS OR INDUSTRY HUTZLERS | |
| 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME CHARLES P. RILEY | | 14. MOTHER'S MAIDEN NAME LILLY MATTHEWS | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 215-10-6337A | |
| 17. INFORMANT CHARLOTTE BROWN - 646 REGENER AVE. | | ADDRESS REGENER AVE. | |
| 18. CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH Several years | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Arteriosclerotic Heart Disease | | (A) DUE TO | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | (C) DUE TO | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | |
| 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from January 19 66 to April 19 67 , that (I) (we) last saw the deceased alive on April 26 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | 23A. SIGNATURE Loy M. Zimmerman M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | |
| 23B. DATE SIGNED 4/30/67 | | 23C. PHYSICIAN'S NAME (Type) Loy M. Zimmerman M.D. | |
| 23D. ADDRESS 3202 Harford Rd, Baltimore, Md 21218 | | 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | |
| 24B. DATE 5/3/67 | | 24C. NAME OF CEMETERY or CREMATORY LOUDON PARK | |
| 24D. LOCATION (City, town, or county) BALTIMORE, MARYLAND | | 25A. DATE REC'D BY HEALTH DEPT. MAY 2 1967 | |
| 25B. NAME OF REGISTRAR Robert E. Feltman | | 25C. FUNERAL DIRECTOR Frederick J. Ruck ADDRESS 5305 HARFORD RD. | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>67 4295</u> | |
|--|----------------------|---|---|--|---|
| BIRTH NO. <u>67 4295</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) <u>Charles Preston Reynolds</u> | | 2. DATE AND HOUR OF DEATH
<u>4/29/67</u> <u>5:00 p.m.</u> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <u>Md.</u> B. COUNTY <u>Balto Co.</u> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>Johns Hopkins Hosp.</u> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>Baltimore</u> <u>21206</u> <u>53-00</u> | | | |
| D. STREET ADDRESS (If rural, give location)
<u>1209 64 th. Street</u> | | | | | |
| 5. SEX
<u>M.</u> | 6. RACE
<u>W.</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
<u>MARRIED</u> | 8. DATE OF BIRTH
<u>JUNE 7, 1912</u> | 9. AGE (In years last birthday)
<u>54</u> | If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>OFFICE EMPLOYEE</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>WESTERN ELEC. CO.</u> | | 11. BIRTHPLACE (State or foreign country)
<u>MARYLAND</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | 13. FATHER'S NAME
<u>CLARENCE E. REYNOLDS</u> | | 14. MOTHER'S MAIDEN NAME
<u>BESSIE E. MILLER</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>NO</u> | | 16. SOCIAL SECURITY NO.
<u>215-09-4836</u> | | 17. INFORMANT
<u>CLARA M. REYNOLDS</u> | |
| 18. <u>42011</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) DUE TO
<u>Acute coronary occlusion</u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>minutes</u> | |
| (B) DUE TO
<u>Arteriosclerosis of heart</u> | | (C) DUE TO
<u>Old coronary occlusion</u> | | <u>5 years</u>
<u>0 years</u> | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
<u>NO</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (the hospital) attended the deceased from <u>September</u> 19 <u>62</u> to <u>March</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>March 7,</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>E. Paul Coffey Jr., M.D.</u> | | | | 23B. DATE SIGNED
<u>5/1/67</u> | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS
<u>3100 St. Paul Street Baltimore, Md.</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | 24B. DATE
<u>5/3/67</u> | | 24C. NAME OF CEMETERY or CREMATORY
<u>ZION EVANG. Luth. Cem.</u> | |
| 24D. LOCATION (City, town, or county) (State)
<u>BALTO. MD.</u> | | 25A. DATE REC'D BY HEALTH DEPT.
<u>MAY 2 1967</u> | | 25B. NAME OF REGISTRAR
<u>Robert E. Faldut</u> | |
| 25C. FUNERAL DIRECTOR
<u>LEONARD J. RUCK, INC.</u> | | 25D. ADDRESS
<u>BALTO. MD. 21214</u> | | | |



P-600

67 4296

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

67 4296

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

TINA M. PEARRE

2. DATE AND HOUR PRONOUNCED DEAD

4-29-67

10⁰⁰ P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

3 BALTIMORE CITY HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE MARYLAND

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

BALTIMORE

26-34

D. STREET ADDRESS (If rural, give location)

5929 RADECKE AVE

5. SEX

FEMALE

6. RACE

WHITE

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

NEVER MARRIED

8. DATE OF BIRTH

MARCH 31, 1967

9. AGE (In years
last birthday)If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

29

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

NONE

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

HARRY R. PEARRE

14. MOTHER'S MAIDEN NAME

SUSAN L. WOODWARD

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

NONE

17. INFORMANT

ADDRESS

H.M. Woodward - 7815 SUMMITT AVE #34

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

CONGENITAL HEART DISEASE

(ATRIOVENTRICULARIS COMMUNIS)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
WORKNOT WHILE
AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

RUSSELL S. FISHER, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4-30-67

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

5/1/67

23C. NAME OF CEMETERY or CREMATORY

PARKWOOD CEMETERY

23D. LOCATION

(City, town, or county)

BALTO. MD.

(State)

24A. DATE REC'D BY HEALTH DEPT.

MAY 2 1967

24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

LEONARD J. RUCK, INC. BALTO. 14, MD.

ADDRESS

11-11-1944

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 4297 | |
|--|-------------------------|---|--|---|---|
| BIRTH NO. 67 4297 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. OCT. 27 | | | | | |
| 1. NAME OF DECEASED
(Type or Print) Mary Martin | | | 2. DATE AND HOUR OF DEATH
4-28-67 8:50 M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND
Bolton Hill Nursing Center
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE Maryland
B. COUNTY | | |
| 90 | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | | |
| | | | D. STREET ADDRESS (If rural, give location)
4012 Moravia Road 27-01 | | |
| 5. SEX
Female | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Single | 8. DATE OF BIRTH
8-19-1888 | 9. AGE (In years
last birthday)
78 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
NONE | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 13. FATHER'S NAME
Francis Martin | | | 14. MOTHER'S MAIDEN NAME
Clara McCombridge | | |
| 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Mrs. Imelda Seitz ADDRESS same | |
| 18. 422.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH
(A) cerebro vascular accident
DUE TO

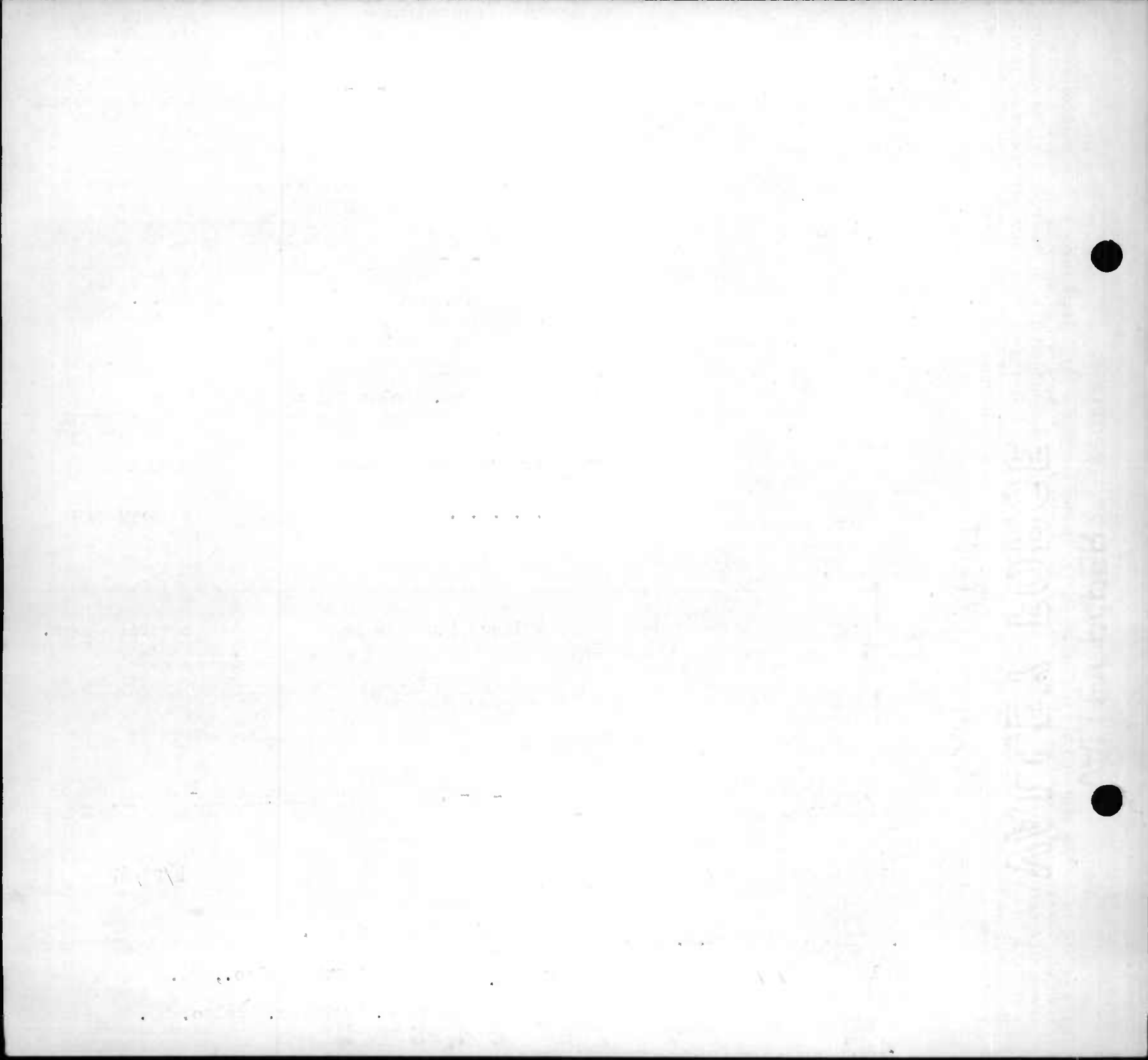
(B) A.S.C.V.D.
DUE TO

(C) | | INTERVAL BETWEEN ONSET AND DEATH

3 days

several yrs |
| | | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Urinary incontinence

several weeks. | | |
| 19A. DATE OF OPERATION
D | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
no | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)
i | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that he (this hospital) attended the deceased from 4-12-67 19 to 4-28 19 67 , that (I) (we) last saw the deceased alive on 4-26 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
E. Ellsworth Cook M.D. | | | 23B. DATE SIGNED
4/28/67 | | Attending Phys. <input type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/> |
| 23C. PHYSICIAN'S NAME (Type)
E. ELLSWORTH COOK M.D. | | | 23D. ADDRESS
M.D. 2431 Maryland Ave. | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
5/1/67 | | 24C. NAME OF CEMETERY or CREMATORY
New Cathedral Cem. | |
| 24D. LOCATION
Balto., Md. | | 25A. DATE REC'D BY HEALTH DEPT.
MAY 2 1967 | | | |
| 25B. NAME OF REGISTRAR
Robert E. Finkbeiner | | 25C. FUNERAL DIRECTOR
Leonard J. Ruck Inc. Balto. Md. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 4298 | |
|---|---------------------|---|--|--|---|
| CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. 67 4298 | | | | | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED
(Type or Print) <i>Mary Hefner</i> | | 2. DATE AND HOUR OF DEATH
<i>4/30/67 1:10 pm</i> M. | | | |
| 3. PLACE OF DEATH <i>IN BALTIMORE, MARYLAND</i> | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <i>W. VA.</i>
B. COUNTY <i>Roanoke</i> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<i>The Johns Hopkins Hospital</i>
<i>33 Baltimore, Md 21205</i> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<i>Roanoke</i>
D. STREET ADDRESS (If rural, give location)
<i>Route #1</i> | | | |
| 5. SEX
<i>F</i> | 6. RACE
<i>W</i> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<i>M</i> | 8. DATE OF BIRTH
<i>1900</i>
<i>10-19-02</i> | 9. AGE (In years last birthday)
<i>66</i> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>housewife</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<i>WEST VIRGINIA</i> | |
| 13. FATHER'S NAME
<i>Wilbert Paugh</i> | | 14. MOTHER'S MAIDEN NAME
<i>SARA LAWRENCE</i> | | 12. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>No</i> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
<i>HAROLD W. HEFNER</i> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)
<i>135.01</i> | | CAUSE OF DEATH
(A) <i>ANOXIA</i>
DUE TO
(B) <i>CARDIAC ARREST</i>
DUE TO
(C) <i>metastatic Carcinoma of ovary</i> | | ADDRESS
<i>(SAME)</i>
INTERVAL BETWEEN ONSET AND DEATH
<i>immediate</i> | |
| 19A. DATE OF OPERATION
<i>2</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<i>yes</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) <u>this hospital</u> attended the deceased from <i>4/30/67 (noon)</i> 19 to <i>4/30/67 (12 pm)</i> 19 that (I) (we) last saw the deceased alive on <i>4/30</i> 19 <i>67</i> and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>we</u> (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<i>James L. Allen</i> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
<i>4/30/67</i> | |
| 23C. PHYSICIAN'S NAME (Type)
<i>JAMES L. ALLEN</i> | | 23D. ADDRESS
<i>Johns Hopkins Hospital</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>BURIAL</i> | | 24B. DATE
<i>5/4/67</i> | | 24C. NAME OF CEMETERY or CREMATORY
<i>WOODSDALE MEM. PARK</i> | |
| 24D. LOCATION (City, town, or county) (State)
<i>GRAFTON, W. VA.</i> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<i>MAY 2 1967</i> | | 25B. NAME OF REGISTRAR
<i>Robert E. Fagley</i> | | 25C. FUNERAL DIRECTOR
<i>LEONARD J. RUCK, Inc. BALTO. 14 MD.</i> | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|---|------------------------------|---|--|
| BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 4299 | |
| BIRTH NO. 67 4299 | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) <i>William Alexander Mackereth</i> | |
| 2. DATE AND HOUR OF DEATH
<i>April 28, 1967 2:30 A.M.</i> | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND
CERTIFICATE AMENDED
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Union Memorial Hospital</i>
5-8-67 | |
| 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE <i>MD</i>
B. COUNTY <i>Baltimore</i> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore 21211</i> | |
| D. STREET ADDRESS (If rural, give location) <i>2833 Huntington Ave</i> | | E. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>12-07</i> | |
| 5. SEX <i>Male</i> | 6. RACE <i>Caucasian</i> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) <i>Married</i> | 8. DATE OF BIRTH <i>3/13/04</i> |
| 9. AGE (In years last birthday) <i>63</i> | 10. UNDER 1 Yr. Months: Days | 11. UNDER 24 Hrs. Hours: Min. | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, except retired) <i>Sales Clerk</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>Auto part-time</i> | |
| 13. FATHER'S NAME <i>Mackereth</i> | | 14. MOTHER'S MAIDEN NAME <i>Unknown</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>220-03-2428</i> | |
| 17. INFORMANT <i>Mrs Ruth J. Mackereth</i> | | ADDRESS <i>Same</i> | |
| 18. <i>490X1</i>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) <i>Acute Bilateral, Diffuse Bronchopneumonia</i>
(B) <i>Arteriosclerotic Cardiovascular disease</i>
(C) <i>Chronic</i> | |
| INTERVAL BETWEEN ONSET AND DEATH | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | |
| 19A. DATE OF OPERATION <i>2</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) <i>Yes</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from <i>4/25</i> 19 <i>67</i> to <i>4/28</i> 19 <i>67</i> , that (1) (we) last saw the deceased alive on <i>4/28</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE <i>Nat E. Watson, Jr.</i> | | 23B. DATE SIGNED <i>4/28/67</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>NAT E. WATSON, JR.</i> | | 23D. ADDRESS <i>THE UNION MEMORIAL HOSPITAL</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>5/1/67</i> | |
| 24C. NAME OF CEMETERY OR CREMATORY <i>Moreland Memorial Cemetery</i> | | 24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>MAY 2 1967</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Fairman</i> | |
| 25C. FUNERAL DIRECTOR <i>Leonard J. Ruck, Inc.</i> | | ADDRESS <i>Balto. Md. 21214</i> | |

United Memorial Hospital
2222 Huntington Ave
Detroit, Mich 48202

Mr. Carson married
5/1/64 02

~~Sakachik~~ part time

Mockereth
Unknown

Mr. Ruth J. Mockereth

Yes

5/2/64 02

5/2/64

Mr. E. Mockereth

+

5/2/64

1
D-236

67 4300

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 4300

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ELLSWORTH DEXTER

2. DATE AND HOUR PRONOUNCED DEAD

April 28, 1967 5:25 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

44
99

Union Memorial Hospital

(DOA)

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

26-02

D. STREET ADDRESS (If rural, give location)

4701 Valleyview Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)
married

8. DATE OF BIRTH

Nov. II, 1905

9. AGE (In years
last birthday)

62 61

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Store Room Keeper

10B. KIND OF BUSINESS OR INDUSTRY

National Gypsum Co.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

Samuel Dexter

14. MOTHER'S MAIDEN NAME

Lillian Price

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.
218-01-3885

17. INFORMANT

Mrs. May V. Dexter

ADDRESS

same

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Arteriosclerotic heart disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

April 28, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

5/2/67

23C. NAME of CEMETERY or CREMATORY

Oaklawn Cem.

23D. LOCATION

(City, town, or county)

Baltimore, Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

MAY 2 1967

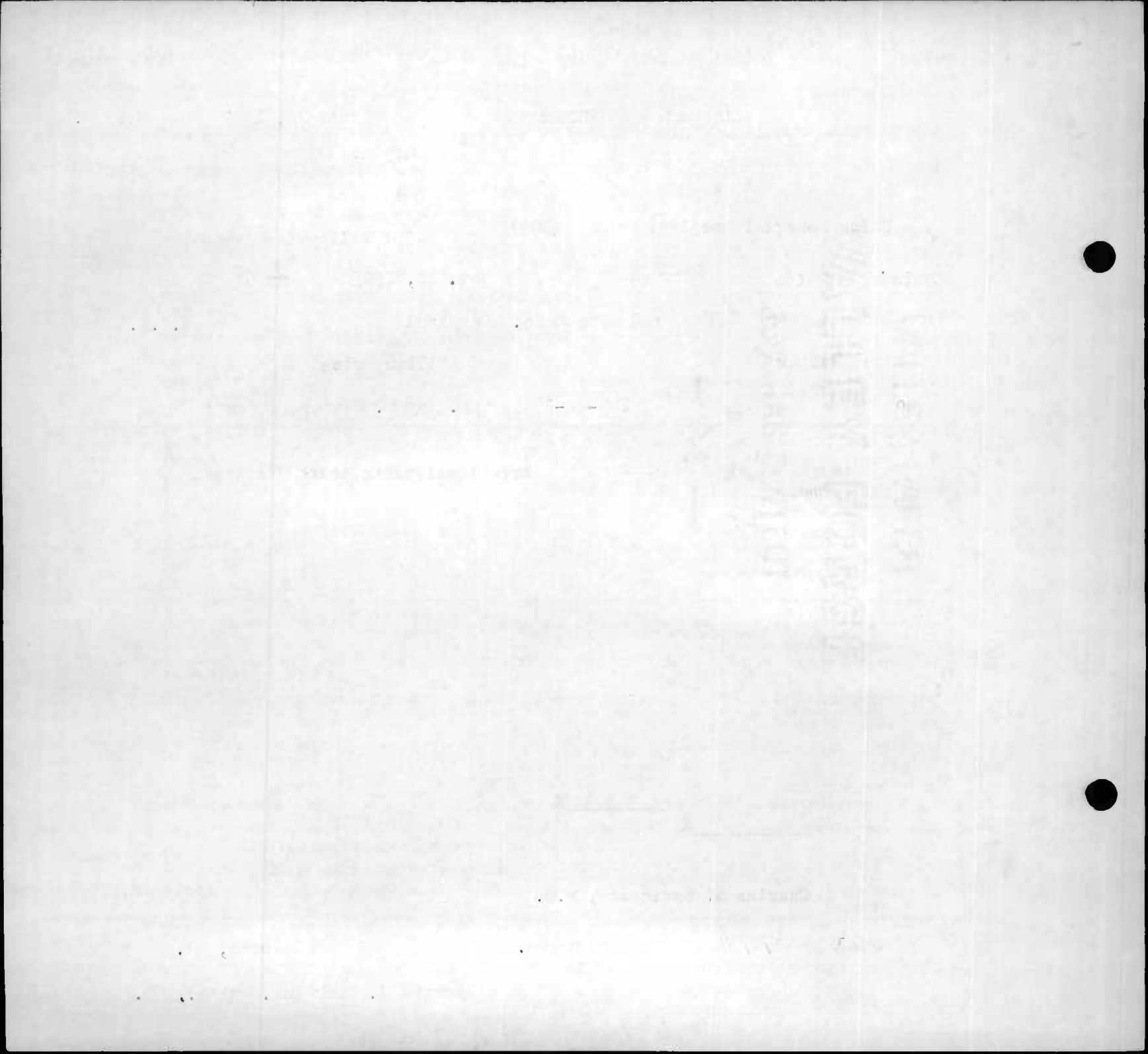
24B. NAME OF REGISTRAR

Robert E. Farkema

24C. FUNERAL DIRECTOR

Leonard J. Ruck Inc. Balto., Md.

ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 4301 | |
|---|-------------------------|---|-------------------------------------|---|--|
| BIRTH NO. 67 4301 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) MABEL R. SELTZER | | 2. DATE AND HOUR OF DEATH
MAY 1, 1967 1:15 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE MD. B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
LAYMANS NURSING HOME
90 5440 BELAIR ROAD | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE 21214 | | D. STREET ADDRESS (If rural, give location)
6004 EDNA AVENUE | |
| 5. SEX
FEMALE | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widow | 8. DATE OF BIRTH
7/9/1884 | 9. AGE (In years last birthday)
82 | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
New York | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
Daniel Roberts, Sr. | | 14. MOTHER'S MAIDEN NAME
Anna Daley | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
212504052 | | 17. INFORMANT ADDRESS
Mrs. Irene C. Williams- 6004 Edna Ave. #14 | |
| 18. 357X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
Fulminating Viral Septicemia
Virus Pneumonia
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Arteriosclerosis, Cerebral Sclerosis. | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (the physician) attended the deceased from 3/17 1967 to 5/1 1967 , that (I) (we) last saw the deceased alive on 5/1 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | 23A. SIGNATURE
L. B. Stevens M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | |
| 23B. DATE SIGNED
5/2/67 | | 23C. PHYSICIAN'S NAME (Type)
L. B. Stevens, M. D. | | 23D. ADDRESS
3400 Erdman Ave. Balto, Md. 21213 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
5/5/67 | | 24C. NAME OF CEMETERY or CREMATORY
Louisa Park Cemetery | |
| 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | | 25A. DATE REC'D BY HEALTH DEPT.
MAY 2 1967 | | 25B. NAME OF REGISTRAR
Robert E. Fisher | |
| 25C. FUNERAL DIRECTOR
LEONARD J. RUCK, Inc. Balto. Md. 21214 | | 25D. ADDRESS | | | |

7/31

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

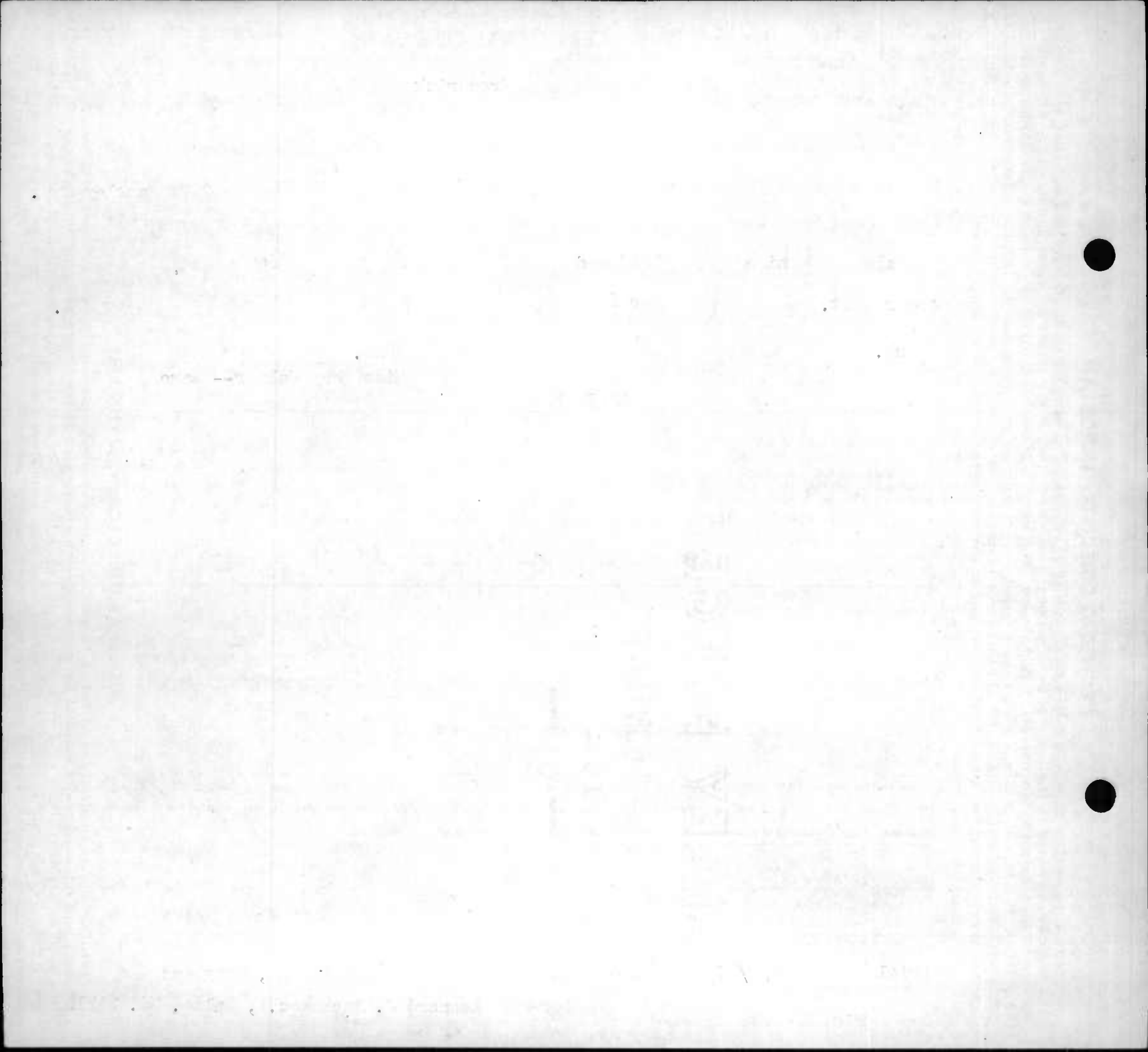
DATE 10/10/01 BY 60322 UCBAW/BJS

EX-100

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

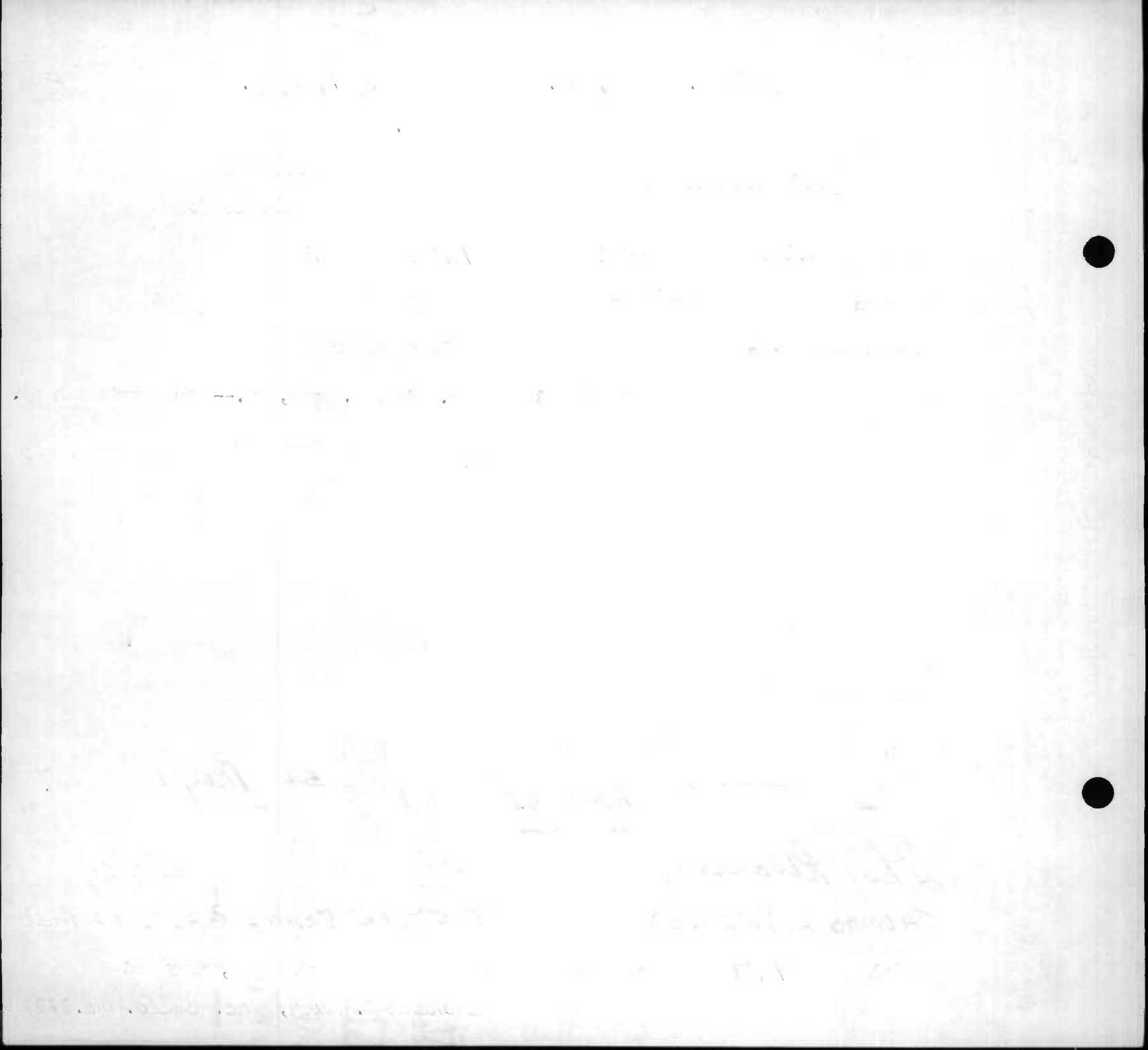
| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. | |
|---|---------|---|---|--|--|
| 67 4302 | | CERTIFICATE OF DEATH | | 67 4302 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED | | 2. DATE AND HOUR OF DEATH | |
| (Type or Print) | | WALTER, Charles Frederick | | May 1, 1967 1:00 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | A. STATE | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | B. COUNTY | | MD | |
| (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | Baltimore 27-02 | |
| Maryland Gen. Hospital | | D. STREET ADDRESS (If rural, give location) | | 2921 Markley Ave. Gould Convalesarium - Belair Rd. | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) |
| Male | White | Widowed | Aug. 8, 1892 | 74 | Sawyer (Ret.) |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? | |
| Wood | | MD | MD | U.S.A. | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | |
| Unk. | | Unk. | | No | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| 212037474 A | | Miss Mary Walter-- Same | | Medical Record. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) | | (A) Pneumonia | | 3/21/67 - 5/1/67 | |
| ANTECEDENT CAUSES | | (B) Gangrene of L. leg | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) CVA - rt. hemiplegia | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 4/18/1967 | | Fair | | No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| (Month) (Day) (Year) (Hour) | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (1) (this hospital) attended the deceased from March 21, 1967 to May 1, 1967 that (1) (we) lost saw the deceased alive on May 1, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | M.D. | | 23B. DATE SIGNED | |
| Youngsik Moon | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | May 1, 1967 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| Youngsik Moon | | Maryland Gen. Hosp. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY | |
| Burial | | 5/4/67 | | Parkwood Cemetery | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| MAY 2 1967 | | Robert E. Farber | | Leonard J. Ruck Inc., Balto. Md. 21214 | |
| 25D. LOCATION (City, town, or county) (State) | | | | | |
| Baltimore, Maryland | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|-------------------------|--|---|--|--|---|--|-----------------------|--|
| CERTIFICATE OF DEATH | | | | | Registered No. 67 4303 | | | | |
| BIRTH NO. 67 4303 | | | | | M.E. CASE NO. | | | | |
| 1. NAME OF DECEASED
(Type or Print) Edwin M. Cade, Sr. | | | | | 2. DATE AND HOUR OF DEATH
May 1, 1967. 3:30 P.M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
00 3602 Kimble Road | | | | | A. STATE Md.
B. COUNTY | | | | |
| (If not in hospital or institution, give street address or location) | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore 9-03 | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location)
3602 Kimble Road | | | | |
| 5. SEX
Male | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married | | 8. DATE OF BIRTH
4/7/1894 | 9. AGE (In years last birthday)
73 | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Salesman | | | 10B. KIND OF BUSINESS OR INDUSTRY
Furniture | | 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA | | |
| 13. FATHER'S NAME
George Edwin Cade | | | | | 14. MOTHER'S MAIDEN NAME
Clara Barber | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | 16. SOCIAL SECURITY NO.
215070051 | | 17. INFORMANT ADDRESS
Mr. Edwin M. Cade, Jr. --- 1014 Dartmouth Rd. | | | | |
| 18. 443 X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Arterio Sclerotic Cardiovascular Disease & Hypertension | | | | | CAUSE OF DEATH
(A) DUE TO
(B) DUE TO
(C) | | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 19 54 to May 1 1967 , that (I) (was) last saw the deceased alive on April 25 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (was) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
Thos. H. Worsley | | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
5/2/67 | | |
| 23C. PHYSICIAN'S NAME (Type)
THOMAS L. WORSLEY | | | | | 23D. ADDRESS
M.D. 6505 YORK ROAD - BALTO 12 MD | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
5/4/67 | | 24C. NAME of CEMETERY or CREMATORY
Baltimore Cemetery | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 2 1967 | | 25B. NAME OF REGISTRAR
Robert E. Farley, M.D. | | 25C. FUNERAL DIRECTOR
Leonard J. Ruck, Inc. Balto. Md. 21214 | | ADDRESS | | | |



FUNERAL DIRECTOR: IMPORTANT

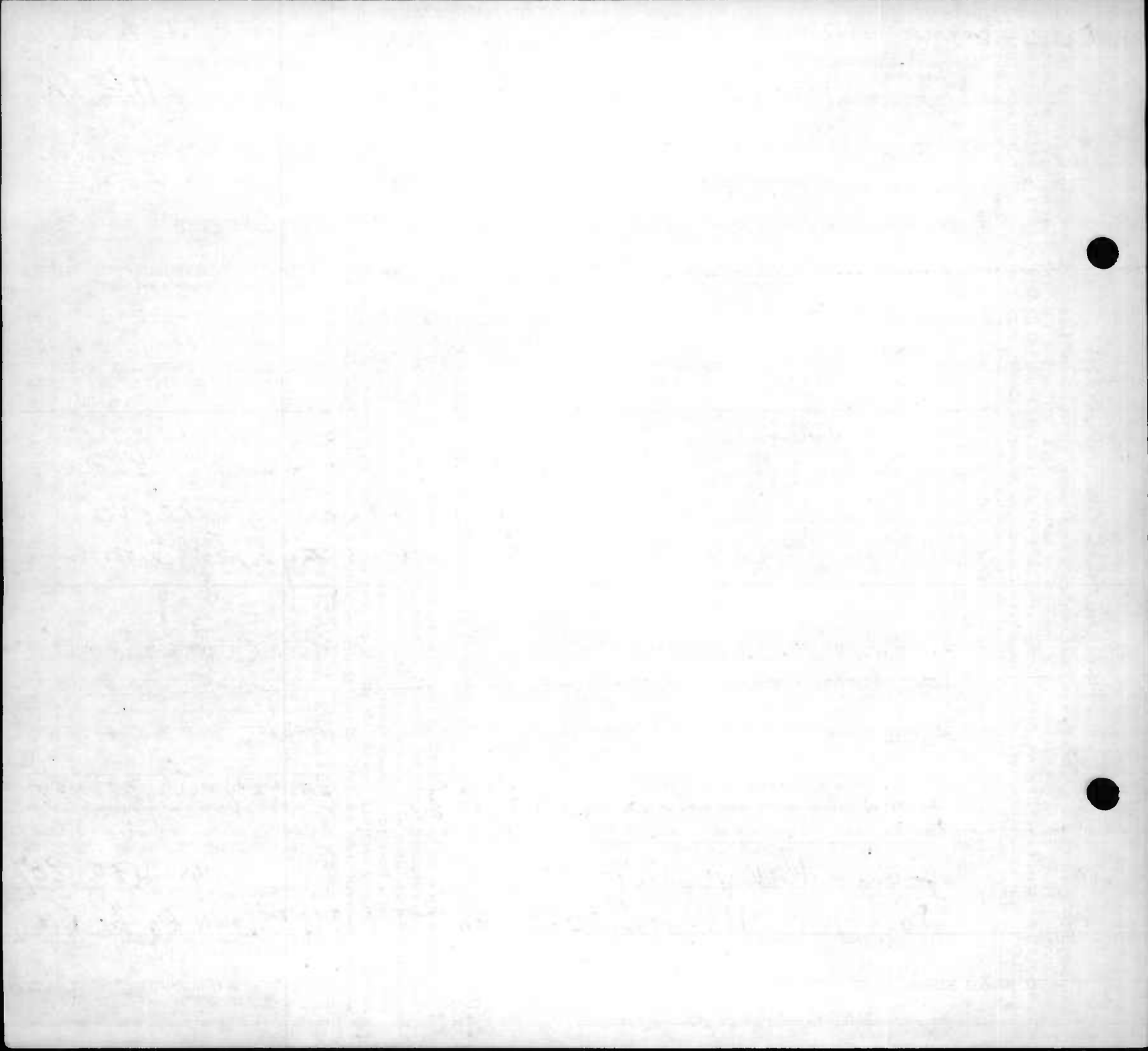
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>67 4304</u> | |
|---|-------------------------|--|--|--|--|
| BIRTH NO. <u>67 4304</u> | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) <u>MAX KRAMER</u> | | 2. DATE AND HOUR OF DEATH
<u>APRIL 30, 1967</u> <u>12³⁰</u> <u>A.</u> M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<u>90 HOUSE IN THE PINES, BELU.</u> | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <u>MD</u>
B. COUNTY
<u>BALTO</u>
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>27-17</u>
D. STREET ADDRESS (If rural, give location)
<u>3327 INGLESDALE AVE</u> | | |
| 5. SEX
<u>M</u> | 6. RACE
<u>WHITE</u> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<u>WIDOWED</u> | 8. DATE OF BIRTH
<u>SEPT, 1884</u> | 9. AGE (In years last birthday)
<u>82</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>TAILOR</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>RUSSIA</u> | |
| 13. FATHER'S NAME
<u>MORRIS</u> | | | 14. MOTHER'S MAIDEN NAME
<u>HANNAH</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>NO</u> | | 16. SOCIAL SECURITY NO.
<u>212-10-8865</u> | | 17. INFORMANT
<u>MRS ROSE MIRVIS</u>
ADDRESS
<u>SAME</u> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
<u>444X</u>

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

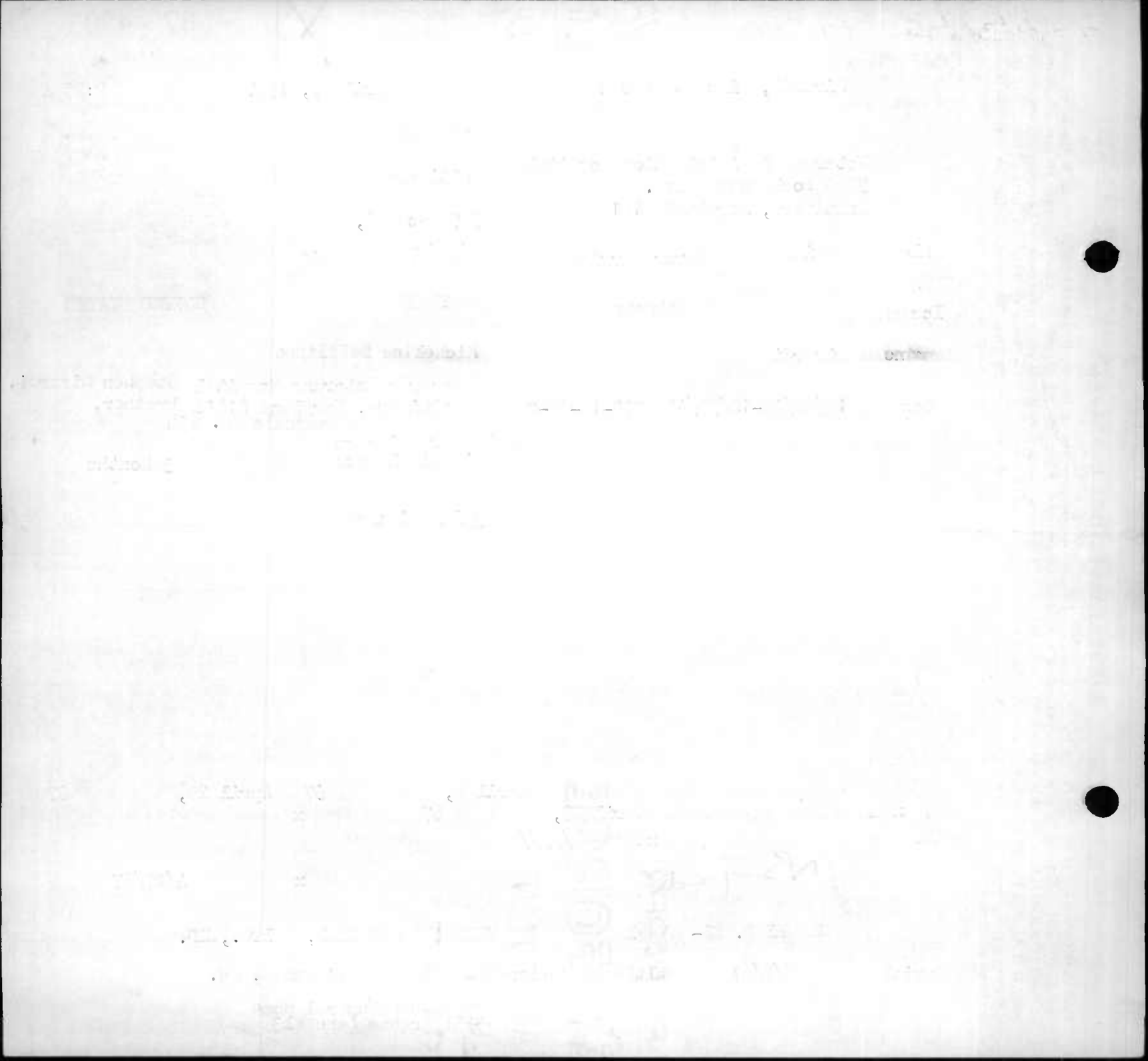
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | CAUSE OF DEATH
(A) DUE TO <u>Heart Failure</u>
(B) DUE TO <u>Hypertension</u>
(C) DUE TO <u>Diabetes & gangrene leg</u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>1 year</u>
<u>10 yrs.</u>
<u>3 yrs.</u> |
| 19A. DATE OF OPERATION
<u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<u>NO</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Sept. 1966</u> to <u>April 30, 1967</u> , that (I) (we) last saw the deceased alive on <u>April 29, 1967</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>Joseph R. Myerowitz</u>
23C. PHYSICIAN'S NAME (Type)
<u>Joseph R. Myerowitz</u> | | | | 23B. DATE SIGNED
<u>April 30, 1967</u> | |
| 23D. ADDRESS
<u>6615 REISTERSTOWN RD BALTO</u> | | 24. LOCATION (City, town, or County) (State)
<u>BALTO</u> <u>MD</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (specify)
<u>BURIAL</u> | | 24B. DATE
<u>4/30/67</u> | | 24C. NAME OF CEMETERY or CREMATORY
<u>ROSEDALE</u> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>MAY 2 1967</u> | | 25B. NAME OF REGISTRAR
<u>R. E. Taylor</u> | | 25C. FUNERAL DIRECTOR
<u>Sylvan S. Levinson INC Garrison, Md</u> | |



FUNERAL DIRECTOR: IMPORTANT

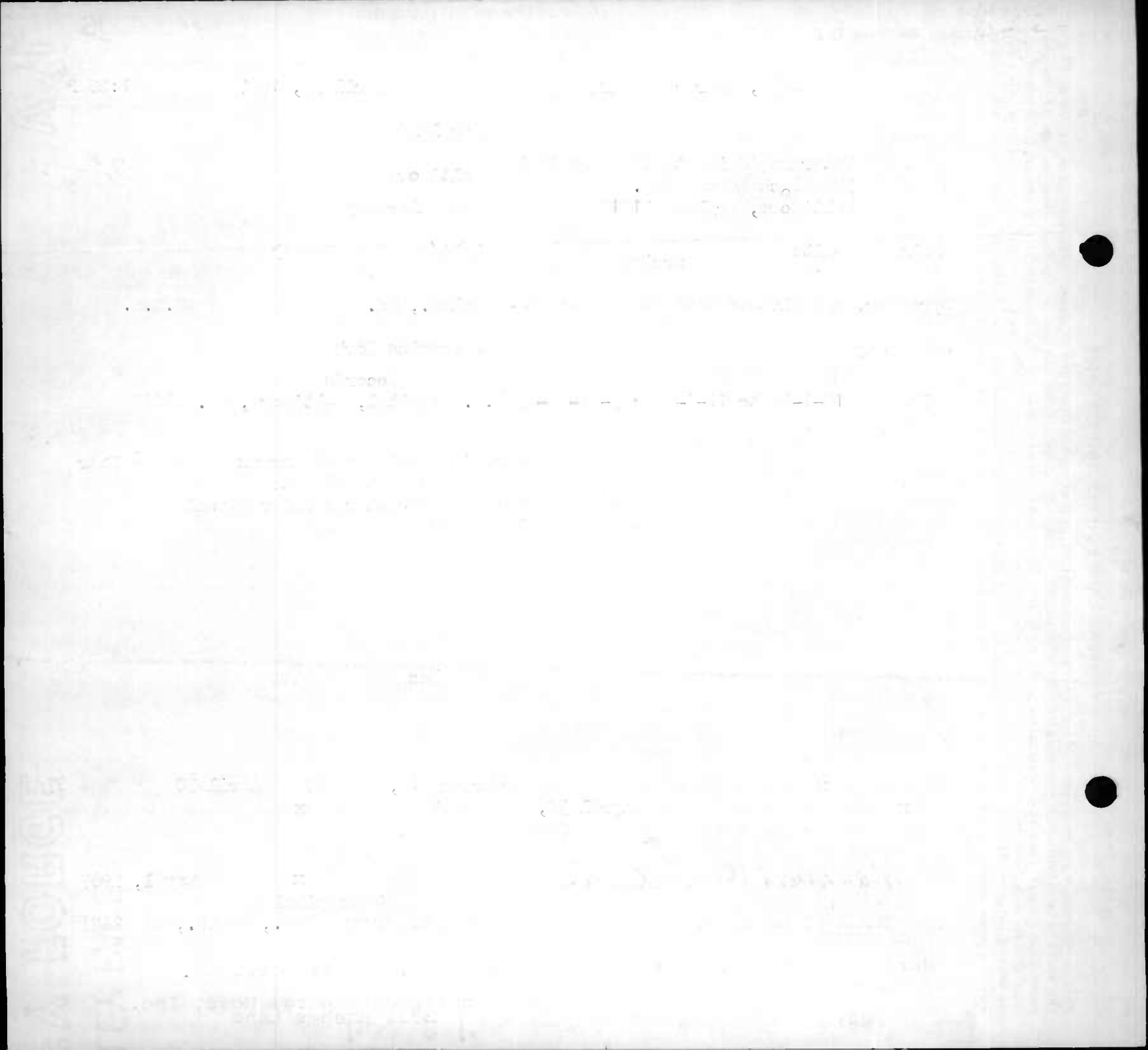
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|---|--|---|--|---|--|--|---|--|
| CERTIFICATE OF DEATH | | | | | Registered No. X | | | | |
| BIRTH NO. 67 4305 | | 67 4305 | | | | | | | |
| M.E. CASE NO. | | | | | DATE AND HOUR OF DEATH | | | | |
| 1. NAME OF DECEASED
(Type or Print) Girardi, Vincent Joseph | | | | | April 29, 1967 9:20 A.M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION Veterans Administration Hospital
27 3900 Loch Raven Blvd.
Baltimore, Maryland 21218 | | | | | A. STATE Maryland Balt Co. | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore 53-00 | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location)
927 Race Rd. | | | | |
| 5. SEX
Male | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Never Married | | 8. DATE OF BIRTH
2/28/07 | 9. AGE (In years lost birthday)
60 | If Under 1 Yr. Months: Days: Hours: Min. | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Iceman | | | 10B. KIND OF BUSINESS OR INDUSTRY
Unknown | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
UNITED STATES | | |
| 13. FATHER'S NAME
Carmine Girardi | | | | | 14. MOTHER'S MAIDEN NAME
Micheline DeFilippo | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
Yes | | | 16. SOCIAL SECURITY NO.
10/20/42-10/30/43 212-10-69-04 | | 17. INFORMANT
Records Veterans Hospital Baltimore, Maryland 21218 | | | ADDRESS
Stephen Girardi, brother, | |
| 18. 201X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
Pulmonary Disease
Mediastinal Mass | | | | | CAUSE OF DEATH 8206 Avondale Rd. #34
INTERVAL BETWEEN ONSET AND DEATH
3 Months | | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | (A) DUE TO
Hodgkins Disease
(B) DUE TO
(C) DUE TO | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION
D | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from April 4, 19 67 to April 29, 19 67 , that (I) (we) last saw the deceased alive on April 29, 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (8/4/67) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
Naguri R. El-Bayadi | | | | | | | 23B. DATE SIGNED
4/29/67 | | |
| 23C. PHYSICIAN'S NAME (Type)
NAGURI R. EL-BAYADI | | | | | 23D. ADDRESS
VETERANS HOSPITAL, BALTO., MD. | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
5/3/67 | | 24C. NAME OF CEMETERY OR CREMATORY
Baltimore National Cemetery | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 2 1967 | | 25B. NAME OF REGISTRAR
Robert E. Taylor, MA | | | 25C. FUNERAL DIRECTOR
Schimunek Funeral Home | | | ADDRESS
3331 Brehms Lane #13 | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

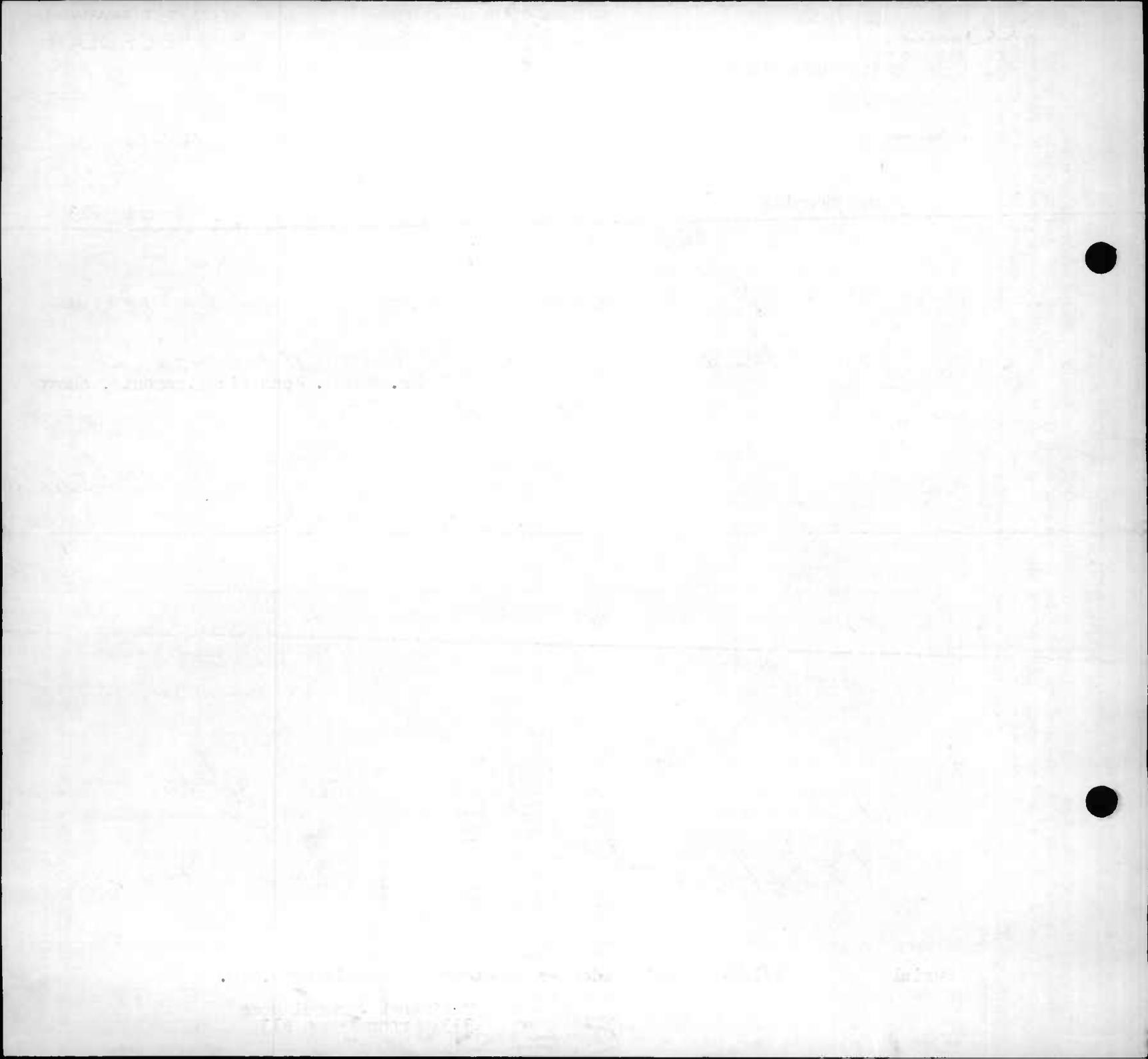
| | | | |
|--|--|--|--|
| BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 4306 | |
| BIRTH NO. 67 4306 | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 2. DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED
(Type or Print) LANG, Charles Edward | | April 30, 1967 1:20 P M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION
27 Veterans Administration Hospital
3900 Loch Raven Blvd.
Baltimore, Maryland 21218 | | A. STATE Maryland
B. COUNTY | |
| 5. SEX Male | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | |
| 6. RACE White | | D. STREET ADDRESS (If rural, give location) 4208 Clareway | |
| 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | | 9. AGE (In years last birthday) 33 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Spreader, Boys Clothes | | 11. BIRTHPLACE (State or foreign country) Balto., Md. | |
| 10B. KIND OF BUSINESS OR INDUSTRY Strouse Baer Co. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME John Lang | | 14. MOTHER'S MAIDEN NAME Josephine York | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES 10-1-42 to 11-6-45 | | 16. SOCIAL SECURITY NO. 215-01-08-09 | |
| 17. INFORMANT Records | | ADDRESS V.A. Hospital, Baltimore, Md. 21218 | |
| 18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
Epidermoid Carcinoma of Larynx with direct extension to adjacent structures and regional lymph nodes | | INTERVAL BETWEEN ONSET AND DEATH 1 year | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION 2/16/68 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from February 16, 1967 to April 30, 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on April 30, 1967 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. (b) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE Margaret Ann Dennis M.D. | | 23B. DATE SIGNED May 1, 1967 | |
| 23C. PHYSICIAN'S NAME (Type) MARGARET ANN DENNIS | | 23D. ADDRESS VA Hospital
3900 Loch Raven Blvd., Balto., Md 21218 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 5/3/67 | |
| 24C. NAME OF CEMETERY OR CREMATORY Baltimore National Cem. | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. MAY 2 1967 | | 25B. NAME OF REGISTRAR Robert E. Fairman | |
| 25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. | | ADDRESS 3331 Brehms Lane | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

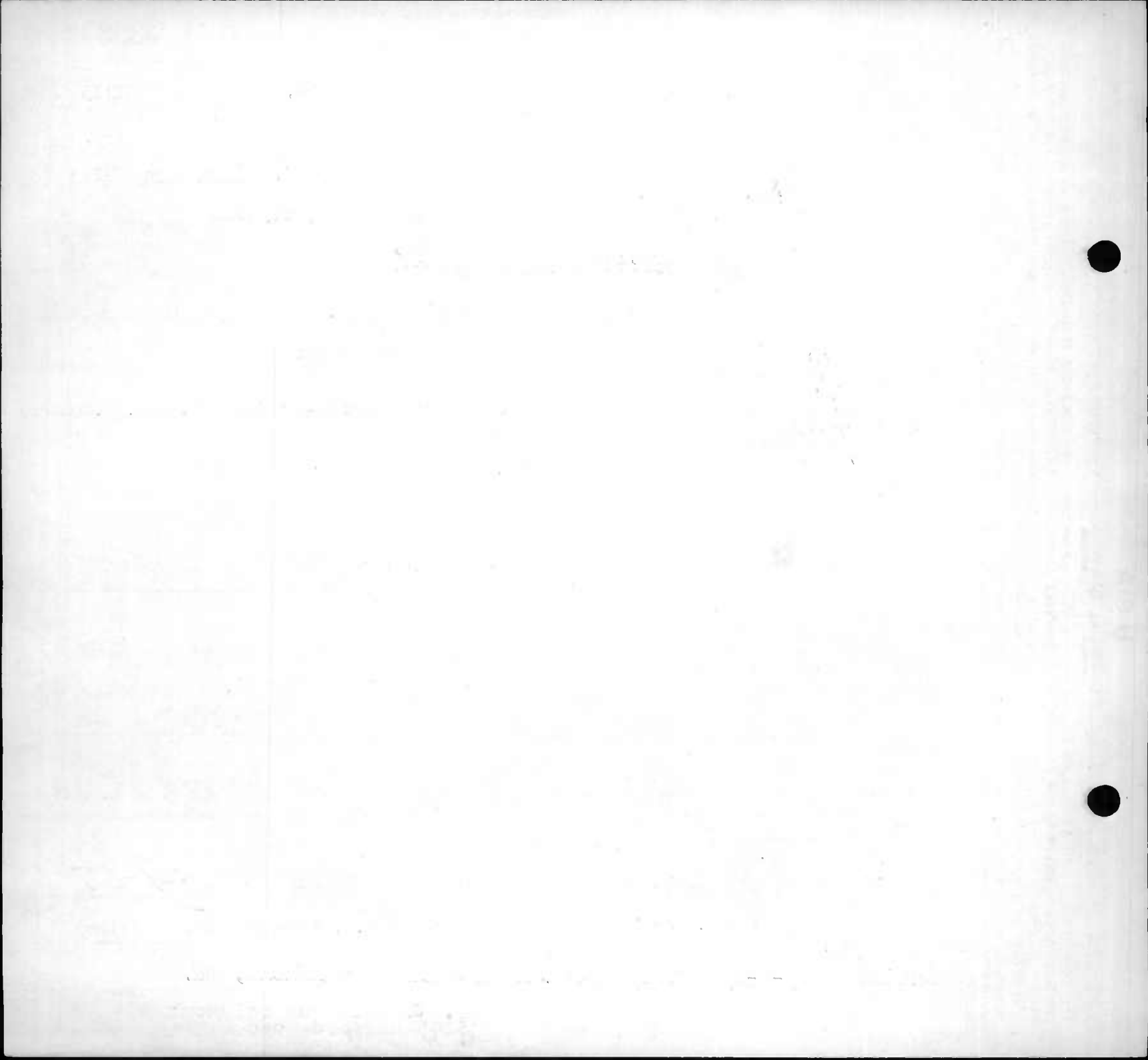
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 4307 | |
|---|-------------------------|--|---------------------------------|--|--|
| BIRTH NO. 67 4307 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED John Jude Baby Ficco | | 2. DATE AND HOUR OF DEATH 4/29/67 9²⁷ A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 37 Mercy Hospital | | A. STATE MD B. COUNTY Balto. | | | |
| (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | |
| | | D. STREET ADDRESS (If rural, give location) 4127 Coleman Avenue #13 | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MM | 8. DATE OF BIRTH 4/28/67 | 9. AGE (In years last birthday) 0 | If Under 1 Yr. Months: Days: Hours: Min. 0 12 0 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MB child | | 10B. KIND OF BUSINESS OR INDUSTRY none | | 11. BIRTHPLACE (State or foreign country) Balto. Md | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME John Ficco | | | |
| 14. MOTHER'S MAIDEN NAME Jo Ann Shiner | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) none | | | |
| 16. SOCIAL SECURITY NO. none | | 17. INFORMANT Mr. & Mrs. John Ficco, parents, above | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | (A) DUE TO Hydroic Membrane Disease & CNS | | 12 hours | |
| ANTECEDENT CAUSES | | (B) DUE TO anaphylactic shock | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) _____ | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 4/28/67 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED none | | 20A. AUTOPSY? (Yes or No) no | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) none | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) none | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 4/28/67 | | 21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? none | |
| 22. I certify that (I) (this hospital) attended the deceased from 4/28 19 67 to 4/29 19 67 , that (I) (we) last saw the deceased alive on 4/29 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE W. Schwartz | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 4/29/67 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS M.D. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | 24B. DATE 5/1/67 | 24C. NAME of CEMETERY or CREMATORY Holy Redeemer Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. MAY 2 1967 | | 25B. NAME OF REGISTRAR Robert E. Fisher | | 25C. FUNERAL DIRECTOR Schimunek Funeral Home 3331 Brehm Lane #13 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|--|--|--|--|--|
| BIRTH NO. 67 4308 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 4308 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | MRS MAGDALEN E. LANGREHR | | APRIL 30, 1967 12:15 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY | | 5. CITY OR TOWN (If outside city limits, write RURAL and give township) | |
| FULL NAME OF HOSPITAL OR INSTITUTION
91 JENKINS MEMORIAL HOSPITAL
1000 S. Caton Ave.
Baltimore, Md. 21229 | | Maryland | | 3301 Dorchester Rd. Baltimore 21215 | |
| 6. RACE
W | | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
WIDOWED | | 8. DATE OF BIRTH
July 26, 1884 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 9. AGE (in years last birthday)
82 | |
| Housewife | | - - | | 11. BIRTHPLACE (State or foreign country)
Baltimore, Md. | |
| 13. FATHER'S NAME
Thomas J. Kurdle | | 14. MOTHER'S MAIDEN NAME
Margaretha Schultz | | 12. CITIZEN OF WHAT COUNTRY?
U S A | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
220 46 0434 | | 17. INFORMANT ADDRESS
Medical Records-Jenkins Mem. Hosp. (M. Kohler) | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
4-30-01 | | CAUSE OF DEATH
(A) DUE TO
Gen arteriosclerosis
(B) DUE TO
ASHD = CHF
(C) DUE TO
Gastroenteritis | | INTERVAL BETWEEN ONSET AND DEATH
years
years
weeks | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from JUNE 1966 to APRIL 30 1967 , that (I) (we) last saw the deceased alive on APRIL 29 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
M. de J. Rodriguez | | | | 23B. DATE SIGNED
5-1-67 | |
| 23C. PHYSICIAN'S NAME (Type)
M. de J. Rodriguez | | | | 23D. ADDRESS
Linden & S.W. Blvd- Arbutus. (Office) | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
burial | | 24B. DATE
5-3-67 | | 24C. NAME OF CEMETERY or CREMATORY
Holy Redeemer Cemetery | |
| 24D. LOCATION (City, town, or county) (State)
Baltimore, Md. | | 25A. DATE REC'D BY HEALTH DEPT.
MAY 2 1967 | | 25B. NAME OF REGISTRAR
Robert E. Taylor, M.D. | |
| 25C. FUNERAL DIRECTOR
L. J. Ruck Funeral Home | | 25D. ADDRESS
5305 Harford Road | | 25E. DATE OF DEATH
APRIL 30 1967 | |



FUNERAL DIRECTOR: IMPORTANT

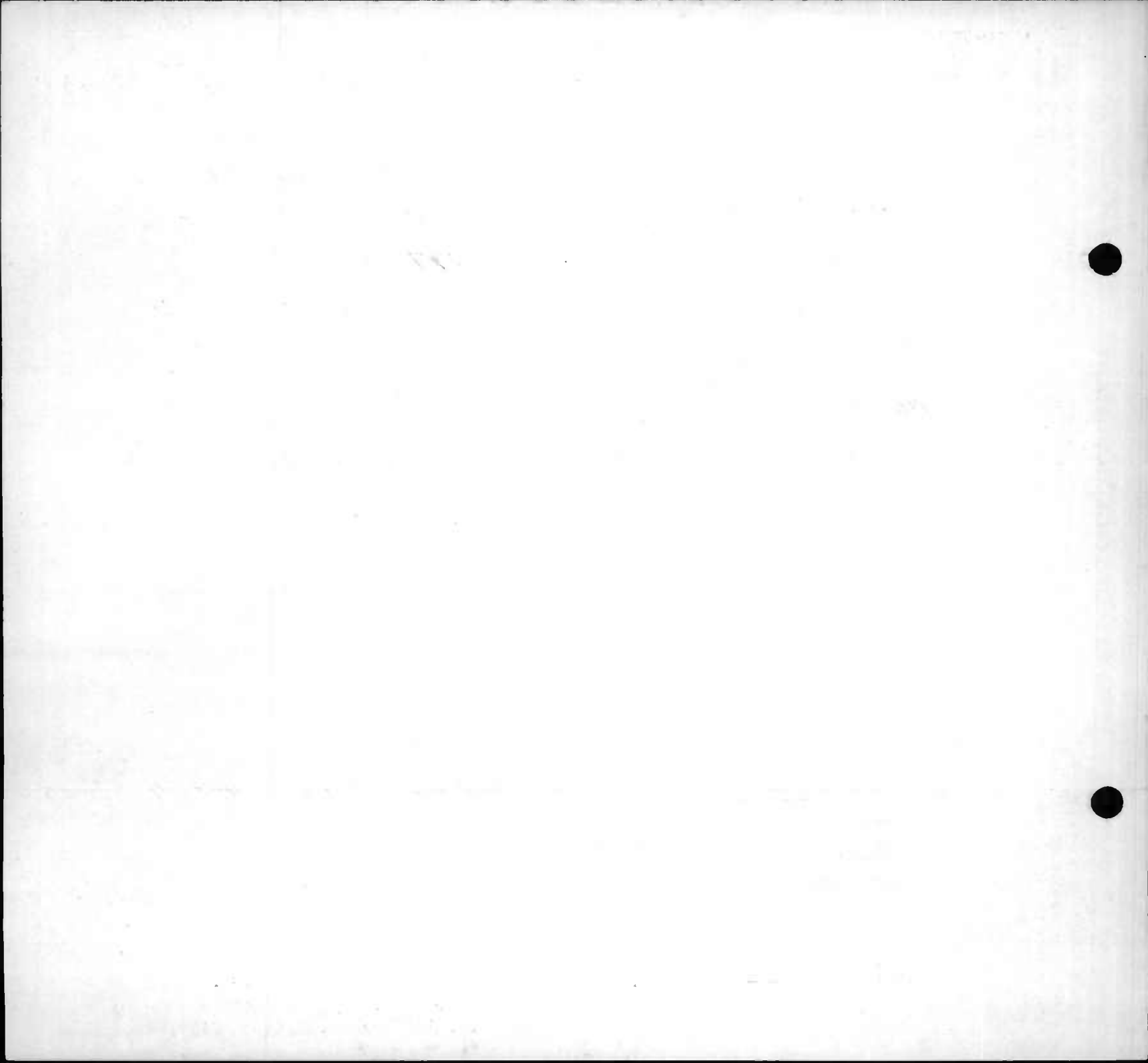
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 67 4309 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 4309 | |
|--|-------------------------|---|------------------------------------|--|---|--|---|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) <i>LeRoy F. Phillips</i> | | | | 2. DATE AND HOUR OF DEATH
<i>28th April 1967 12:45 P.M.</i> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<i>34 Bon Secours Hospital</i> | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE <i>Maryland</i> B. COUNTY <i>Howard Co.</i>
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Howard Co. 63-00</i>
D. STREET ADDRESS (If rural, give location) <i>Elchester Rd.</i> | | | |
| 5. SEX
<i>male</i> | 6. RACE
<i>white</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
<i>married</i> | 8. DATE OF BIRTH
<i>7/17/91</i> | 9. AGE (In years last birthday)
<i>75</i> | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Retired</i> | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<i>Baltimore</i> | | 12. CITIZEN OF WHAT COUNTRY?
<i>U.S.</i> |
| 13. FATHER'S NAME
<i>John Phillips</i> | | | | 14. MOTHER'S MAIDEN NAME
<i>Marg O'donohue</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>No</i> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| 18. <i>420.01</i>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

<i>II</i>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | CAUSE OF DEATH
(A) DUE TO <i>Congestive Failure</i>
(B) DUE TO <i>Arterial H.D.</i>
(C) _____ | | INTERVAL BETWEEN ONSET AND DEATH
<i>Chr</i>
<i>2 yrs +</i> | |
| 19A. DATE OF OPERATION
<i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<i>No</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>4/17</i> 19 <i>67</i> to <i>4/27</i> 19 <i>67</i> , that (I) (we) lost saw the deceased alive on <i>4/27</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
<i>S. R. Park</i> M.D. | | | | 23B. DATE SIGNED
<i>4/27/67</i> | | | |
| 23C. PHYSICIAN'S NAME (Type)
<i>S. R. Park</i> | | | | 23D. ADDRESS
<i>Bon Secours Hospital</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 24B. DATE
<i>5-2-1967</i> | | 24C. NAME of CEMETERY or CREMATORY
<i>St. Marys</i> | | 24D. LOCATION (City, town, or county) (State)
<i>Elchester, Md.</i> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<i>MAY 2 1967</i> | | 25B. NAME OF REGISTRAR
<i>Robert E. Tarkenton</i> | | 25C. FUNERAL DIRECTOR
<i>F.C. Higginbotham</i> | | ADDRESS
<i>Ellicott City, Md</i> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 67 4310 | | BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | Registered No. 67 4310 | |
|---|-------------------------|---|---|--|---|
| M.E. CASE NO. | | | 2. DATE AND HOUR OF DEATH | | |
| 1. NAME OF DECEASED
(Type or Print) HARBIN, HUBERT M. | | | APRIL 28, 1967 5:45 A.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND
ST. AGNES HOSPITAL | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND B. COUNTY HOWARD Co. | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location)
WILKENS & CATON AVES.
BALTO., MD. 21229 | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
ELLICOTT CITY | | |
| D. STREET ADDRESS (If rural, give location)
RT #2-OLD FREDERICK RD.-ST. JOHN'S | | | LANE 63-00 | | |
| 5. SEX
MALE | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
SINGLE | 8. DATE OF BIRTH
1908 | 9. AGE (In years lost birthday)
59 | 10. If Under 1 Yr. Months Days Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired | | | 10B. KIND OF BUSINESS OR INDUSTRY
Farmer | | 11. BIRTHPLACE (State or foreign country)
TENNESSEE |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | | 13. FATHER'S NAME
PHILIP HARBIN | | |
| 14. MOTHER'S MAIDEN NAME
MINOTIE (COWAN) | | | DEC'D | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | | 16. SOCIAL SECURITY NO.
? | | |
| 17. INFORMANT
ST. AGNES RECRDS | | | ADDRESS
BALTO., MD. 21229 | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
422.21 | | | CAUSE OF DEATH
(A) Hepatic Coma | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II | | | INTERVAL BETWEEN ONSET AND DEATH
4 Days | | |
| 19A. DATE OF OPERATION
0 | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | |
| 20A. AUTOPSY? (Yes or No)
No | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | |
| 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from APRIL 24, 1967 to APRIL 28, 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on APRIL 28, 1967 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. (<input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> view the body after death. | | | | | |
| 23A. SIGNATURE
<i>A. Mejia</i> | | | 23B. DATE SIGNED
4-28-67 | | |
| 23C. PHYSICIAN'S NAME (Type)
A. MEJIA | | | 23D. ADDRESS
ST. AGNES HOSPITAL-BALTO., MD. 21229 | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
5-1-1967 | | 24C. NAME OF CEMETERY or CREMATORY
Good Shepherd | |
| 24D. LOCATION (City, town, or county) (State)
Ellicott City, Md. | | 25A. DATE REC'D BY HEALTH DEPT.
MAY 2 1967 | | | |
| 25B. NAME OF REGISTRAR
<i>R. C. Higginbotham</i> | | 25C. FUNERAL DIRECTOR
<i>R. C. Higginbotham</i> | | | |
| ADDRESS
Ellicott City, Md. | | | | | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|-----------|---|---------------------------|--|---|
| BIRTH NO. 63267 4311 | | CITY HEALTH DEPARTMENT | | Registered No. 67 4311 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | DATE AND HOUR OF DEATH 29 April 67 4:45 p.m. | |
| 1. NAME OF DECEASED HARTZLER, Herbert Clarence
(Type or Print) HARTZLER, HERBERT | | 2. DATE AND HOUR OF DEATH | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
48 Maryland General Hosp | | A. STATE DELAWARE
B. COUNTY DELMAR
C. CITY OR TOWN (If outside city limits, write RURAL and give township) V-07
D. STREET ADDRESS (If rural, give location) Rt 1 (Whitesville) | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 11-20-13 | 9. AGE (In years last birthday) 54 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER - poultryman | | 10B. KIND OF BUSINESS OR INDUSTRY FARM | | 11. BIRTHPLACE (State or foreign country) Ohio | |
| 13. FATHER'S NAME Clarence K. HARTZLER | | 14. MOTHER'S MAIDEN NAME Crystal Southerner | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes War II | | 16. SOCIAL SECURITY NO. 276-12-4161 | | 17. INFORMANT Mrs. Mildred Hartzler, Whitesville, Delaware | |
| 18. 330 XI DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH (A) Subarachnoid Hemorrhage | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO | | | |
| (C) DUE TO | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 27 April 67 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Subarachnoid Hemorrhage | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from 19 April 1967 to 29 April 1967, that (1) (we) last saw the deceased alive on 29 April 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Michael B. Lyon | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 29 April 67 | |
| 23C. PHYSICIAN'S NAME (Type) MICHAEL B. LYON | | 23D. ADDRESS Maryland General Hosp | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE May 3, 1967 | | 24C. NAME OF CEMETERY or CREMATORY Parsons Cemetery | |
| 24D. LOCATION Salisbury, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. MAY 2 1967 | | | |
| 25B. NAME OF REGISTRAR R. E. Taylor, MA | | 25C. FUNERAL DIRECTOR ADDRESS HOLLOWAY & COMPANY, SALISBURY, MARYLAND | | | |

Part 2 of 2

Madison Avenue

M. W. ...

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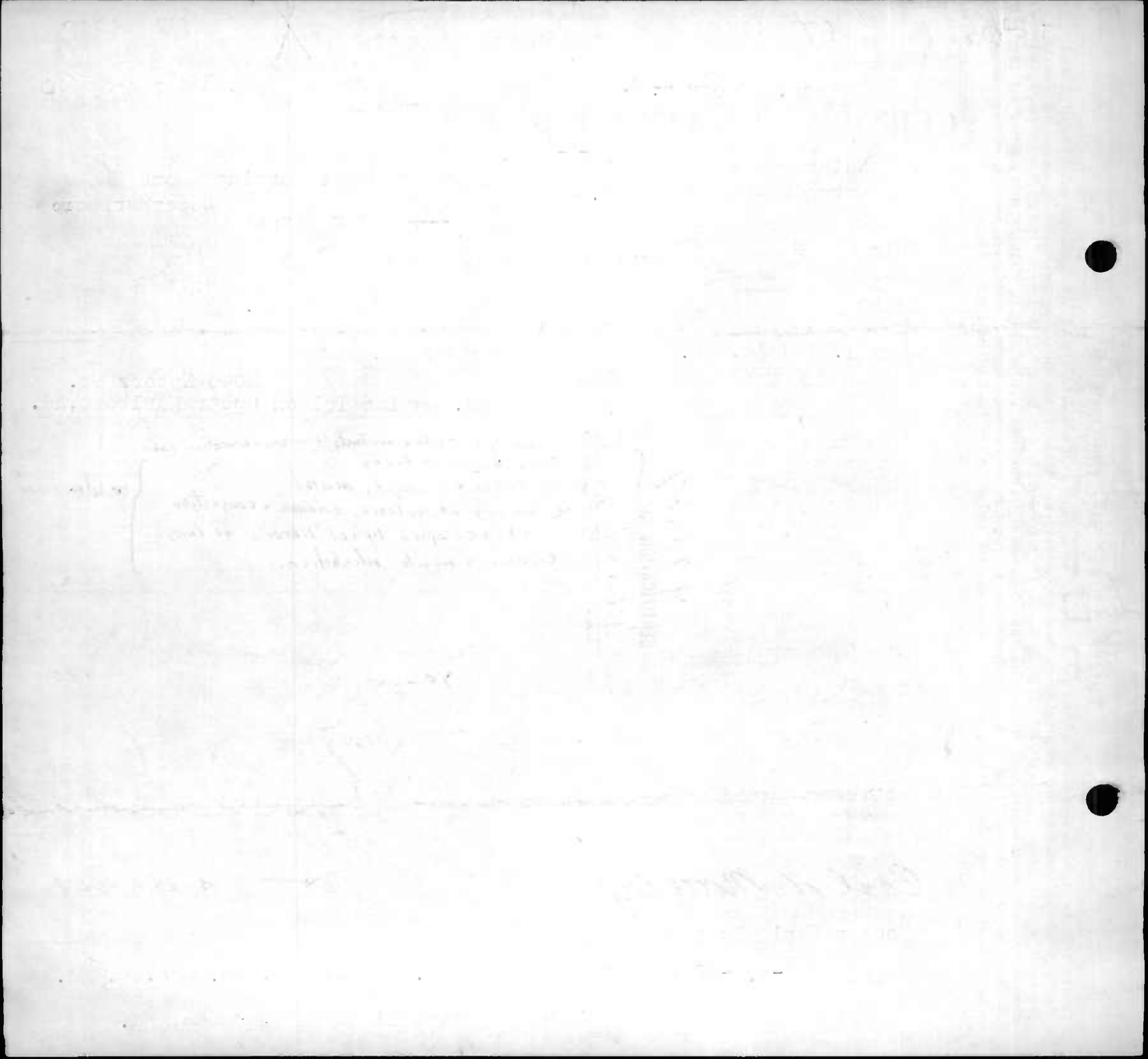
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Michael B. ...

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 4312 | |
|--|--------------|---|---|---|--|
| BIRTH NO. 67 4312 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | Tolson, Emory J. I. | | April 24th, 1967 8:55 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | |
| CERTIFICATE AMENDED
FULL NAME OF HOSPITAL OR INSTITUTION
Saint Agnes Hospital
Caton & Wilkens Aves.
2129 | | A. STATE
Maryland | | | |
| | | B. COUNTY
Prince Georges Co. | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| | | Taylor Manor Nursing Home 66-00 | | | |
| | | D. STREET ADDRESS (If rural, give location) | | | |
| | | 4049 Water Street Upper Marlboro | | | |
| 5. SEX
Male | 6. RACE
N | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
married | 8. DATE OF BIRTH
10/19/31 | 9. AGE (In years lost birthday)
35 | 10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Clerk | | | | Upper Marlboro, Md. | |
| 13. FATHER'S NAME
Emory I. Tolson, Sr. | | | 14. MOTHER'S MAIDEN NAME
Bessie M. Proctor | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
4040 Water St.
Mrs. Maxine Tolson Upper Marlboro, Md. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g. heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH
Aspirated gastric contents trachea & bronchial tubes
Fatty changes in liver
gastroenteritis & esophagitis acute
Pulmonary atelectasis, edema & congestion
DUE TO Chronic Complex Apical fibrosis of lungs
Chronic & Acute Alcoholism | | INTERVAL BETWEEN ONSET AND DEATH
undetermined | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Carl H. Matthey | | | | 23B. DATE SIGNED
4-25-1967 | |
| 23C. PHYSICIAN'S NAME (Type)
Doctor Carl Matthey | | | | 23D. ADDRESS
M.D. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
4-28-67 | | 24C. NAME OF CEMETERY OR CREMATORY
Lincoln Memorial Cem. | |
| 24D. LOCATION (City, town, or county) (State)
Suitland, Pr. Geo. Co. Md. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 2 1967 | | 25B. NAME OF REGISTRAR
Polym E. Taylor | | 25C. FUNERAL DIRECTOR
Martell Adams | |
| | | | | ADDRESS
Aguasco, Md. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 67 4313 | | BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | Registered No. 67 4313 | |
|---|--|--|---|--|--|
| M.E. CASE NO. | | | 2. DATE AND HOUR OF DEATH | | |
| 1. NAME OF DECEASED
(Type or Print) <u>Holley, Thomas H.</u> | | | 5-2-67 4 a.m. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<u>North Charles General Hospital</u> | | | A. STATE <u>MD.</u>
B. COUNTY <u>Baltimore</u> | | |
| 5. SEX <u>Male</u> | | | 8. DATE OF BIRTH <u>4-16-99</u> | | |
| 6. RACE <u>NEGRO</u> | | | 9. AGE (In years last birthday) <u>68</u> | | |
| 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Widowed</u> | | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> | | |
| 11. BIRTHPLACE (State or foreign country) <u>MD.</u> | | | 12. CITIZEN OF WHAT COUNTRY? <u>United States</u> | | |
| 13. FATHER'S NAME <u>Charles Holley</u> | | | 14. MOTHER'S MAIDEN NAME <u>Maggie</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u> | | | 16. SOCIAL SECURITY NO. | | |
| 17. INFORMANT <u>Chart</u> | | | ADDRESS <u>North Charles General Hospital</u> | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
<u>Uremia</u> | | | CAUSE OF DEATH | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.
<u>Chronic Nephritis</u> | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>No</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>3-20-67</u> to <u>5-2-67</u> , that (I) (we) last saw the deceased alive on <u>5-1-67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>F. L. Latham</u> | | | | 23B. DATE SIGNED <u>5-2-67</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>Dr. Seidel</u> | | | | 23D. ADDRESS <u>2404 EUTAW PLACE #21217</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>5/5/67</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Mt. Auburn Cem</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>Balto. Maryland</u> | | 25A. DATE REC'D BY HEALTH DEPT. <u>MAY 3 1967</u> | | | |
| 25B. NAME OF REGISTRAR <u>Robert E. Finkbeiner</u> | | 25C. FUNERAL DIRECTOR <u>Earl Gilmore</u> | | | |
| 25D. ADDRESS <u>1827 W. North Ave</u> | | | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|-------------------------|--|-----------------------------------|--|---|
| BIRTH NO.
M.E. CASE NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. | |
| 1. NAME OF DECEASED
(Type or Print)
<i>Harris Mrs. Evelyn</i> | | 2. DATE AND HOUR OF DEATH
<i>5:40 AM April 29/67 M.</i> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE <i>Maryland</i> B. COUNTY <i>America</i> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<i>34 Bon Secours Hospital</i>
<i>Baltimore, Md.</i> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<i>Baltimore</i> | | | |
| (If not in hospital or institution, give street address or location) | | D. STREET ADDRESS (If rural, give location)
<i>2634 LAWRETTA Ave. #23</i> | | | |
| 5. SEX
<i>7</i> | 6. RACE
<i>Negro</i> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<i>Married</i> | 8. DATE OF BIRTH
<i>5-7-12</i> | 9. AGE (In years last birthday)
<i>54</i> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Teacher</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<i>Maryland</i> | |
| 13. FATHER'S NAME
<i>Issac F. Welton</i> | | 14. MOTHER'S MAIDEN NAME
<i>Edna Cooper</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
<i>219-20-9931</i> | | 17. INFORMANT
<i>Elaine Locke</i> ADDRESS
<i>3736 Reisterstown Rd.</i> | |
| 18. <i>443X1</i>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) <i>SUBARACHNOID AND INTRACEREBRAL HEMORRHAGE.</i>
(B) <i>HYPERTENSIVE CARDIOVASCULAR Disease</i>
(C) | | INTERVAL BETWEEN ONSET AND DEATH
<i>1 day</i>
<i>YEARS</i> | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
<i>2</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<i>Yes</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>April 28/1967</i> to <i>April 29/1967</i> , that (I) (we) last saw the deceased alive on <i>April 29/1967</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<i>A.H. Ghiladi</i> M.D. | | 23B. DATE SIGNED
<i>4/29/67</i> | | 23C. PHYSICIAN'S NAME (Type)
<i>Abdolhamid Ghiladi</i> M.D. | |
| 23D. ADDRESS
<i>Bon Secours Hospital</i> | | 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | | | |
| 24B. DATE
<i>5/3/67</i> | | 24C. NAME OF CEMETERY or CREMATORY
<i>Mt. Auburn</i> | | 24D. LOCATION (City, town, or county) (State)
<i>Baltimore Md.</i> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<i>MAY 3 1967</i> | | 25B. NAME OF REGISTRAR
<i>Paul E. Taylor</i> | | 25C. FUNERAL DIRECTOR
<i>Arington Phelps</i> ADDRESS
<i>1727 N. Mount.</i> | |

MAILED 10-10-1950

2524 E. 12th St.
Baltimore, Md.

2524 E. 12th St.
Baltimore, Md.

2-1-12

2-1-12

2

DISCLOSURE OF INFORMATION
RECEIVED
2524 E. 12th St.
Baltimore, Md.

252

252

37-68-87TH

W-452 67 4315

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 67 4315

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|-------------------------|--|------------------------------------|---|--|
| BIRTH NO. 67 4315 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 4315 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) HILDA WILLIAMS | | 2. DATE AND HOUR OF DEATH
May 1, 1967 12:15 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
BALTIMORE CITY HOSPITALS
31 4940 EASTERN AVENUE
BALTIMORE, MARYLAND 21224 | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE MARYLAND
B. COUNTY

C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE
D. STREET ADDRESS (If rural, give location)
2445 DRUID HILL AVENUE 21217 | | 13-03 | |
| 5. SEX
FEMALE | 6. RACE
NEGRO | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
MARRIED | 8. DATE OF BIRTH
4-19-20 | 9. AGE (In years last birthday)
47 | If Under 1 Yr. Months Days Hours Min.
If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Nurse Aid | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
VIRGINIA | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
JAMES D. REED | | 14. MOTHER'S MAIDEN NAME
LOTTIE PAGE | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
218-12-7502 | | 17. INFORMANT ADDRESS
BCH, RECORDS 4940 EASTERN AVENUE 21224 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
204.11
CHRONIC MYELOGENOUS LEUK. 5y. | | CAUSE OF DEATH
(A) DUE TO
(B) DUE TO
(C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
YES | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
yes | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from 4/21/67 19 to 5/1 19 67 , that (I) (we) last saw the deceased alive on 4/30/67 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE
Clayton Moravec | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
5/1/67 | |
| 23C. PHYSICIAN'S NAME (Type)
DR. CLAYTON MORAVEC | | 23D. ADDRESS
BALTIMORE CITY HOSPITAL
4940 EASTERN AVENUE BALTO. MD. 21224 | | M.D. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
5/4/67 | | 24C. NAME of CEMETERY or CREMATORY
Arbutus Mem. Ph. Bacteriaria | |
| 24D. LOCATION (City, town, or county) (State)
MD. | | 25A. DATE REC'D BY HEALTH DEPT.
MAY 3 1967 | | 25B. NAME OF REGISTRAR
Robert E. Farkas | |
| 25C. FUNERAL DIRECTOR
Wilmington S. Phillips | | ADDRESS
1727 N. Mount St. | | | |

Chas. W. Johnson

1110
Chas. W. Johnson

Chas. W. Johnson

7

Chas. W. Johnson

1
W-362

67 4316

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 4316

BIRTH NO.

M.E. CASE NO.

| | | | |
|---|---------------------------|--|---------------------------------------|
| 1. NAME OF DECEASED
(Type or Print)
ALBERT E. WATERS | | 2. DATE AND HOUR PRONOUNCED DEAD
4-30-67 10:22 AM | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
1410 N. ROSEDALE STREET | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
1410 N. Rosedale Street 21216 | |
| 5. SEX
Male | 6. RACE
Colored | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
Single | 8. DATE OF BIRTH
12-17-1911 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
U.S. Government Eng | | 10B. KIND OF BUSINESS OR INDUSTRY
Social Security Baltimore, Md. | |
| 11. BIRTHPLACE (State or foreign country)
Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY?
U.S. | |
| 13. FATHER'S NAME
Unknown | | 14. MOTHER'S MAIDEN NAME
Laura B. Waters | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service)
yes W N II | | 16. SOCIAL SECURITY NO.
212-16-6396 | |
| 17. INFORMANT
Laura Waters | | ADDRESS
Same | |

| | | | |
|--|--|--|--|
| 18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Arteriosclerotic cardiovascular disease
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No)
Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
Yes | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.
<input type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Minute) | |
| 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>
CHIEF MEDICAL EXAMINER <input type="checkbox"/>
M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>
ACTUAL SIGNATURE Werner U. Spitz, M.D. DATE SIGNED 5-1-67
EXAMINER'S NAME (Type) WERNER U. SPITZ, M.D. | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 23B. DATE
5-15-67 | |
| 23C. NAME OF CEMETERY or CREMATORY
Baltimore National | | 23D. LOCATION (City, town, or county) (State)
Baltimore Md. | |
| 24A. DATE RECEIVED BY HEALTH DEPT.
MAY 3 1967 | | 24B. NAME OF REGISTRAR
Robert E. Taylor, M.D. | |
| 24C. FUNERAL DIRECTOR
Arlington J. Shelly | | ADDRESS
1727 N. Mount St. | |

WALTER WARD

WALTER WARD

WALTER WARD

WALTER WARD

WALTER WARD

WALTER WARD

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WALTER WARD

WALTER WARD

WALTER WARD

WALTER WARD

WALTER WARD

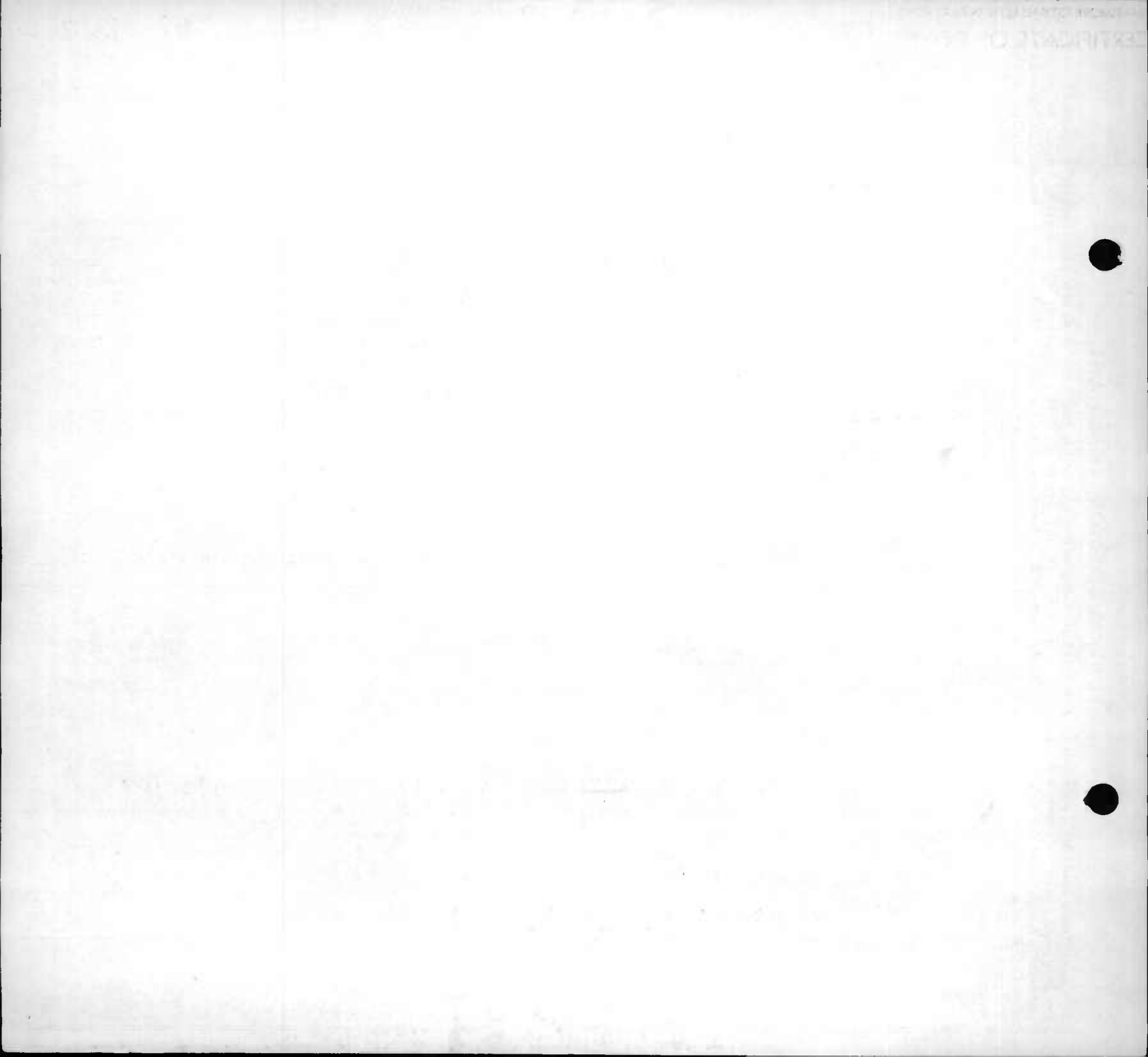
WALTER WARD

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. | |
|---|---------------------|---|-----------------------------------|--|---|
| BIRTH NO. 67 4317 | | CERTIFICATE OF DEATH | | 67 4317 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) SMITH DELLA | | 2. DATE AND HOUR OF DEATH
4/30/67 2 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
LUTHERAN HOSPITAL OF MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE
D. STREET ADDRESS (If rural, give location)
1800 N. Smallwood St | | | |
| 5. SEX
M | 6. RACE
C | 7. MARRIED NEVER MARRIED
WIDOWED DIVORCED (specify)
WIDOWED | 8. DATE OF BIRTH
8-8-88 | 9. AGE (In years last birthday)
78 | 10. Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Va. | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME
Veney | | 12. CITIZEN OF WHAT COUNTRY?
U S D | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
ESTHER STRONG
ADDRESS
SDML | |
| 18. 420.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)
CAUSE OF DEATH
(A) CEREBRO VASCULAR ACCIDENT
DUE TO
WITH B sided Paralysis
(B) DUE TO
(C) ACUTE MYOCARDIAL INFARCTION. | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 4-14-67 19 to 4/30/67 19, that (I) (we) last saw the deceased alive on 4/30/1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
V. Biswanath Pillai
M.D. | | | | 23B. DATE SIGNED
4/30/67 | |
| 23C. PHYSICIAN'S NAME (Type)
V. BISWANATH PILLAI | | 23D. ADDRESS
M.D. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
5-4-67 | | 24C. NAME of CEMETERY or CREMATORY
Carver Mem. Park | |
| 24D. LOCATION
Laurel Md. | | 24E. FUNERAL DIRECTOR
Kelson Funeral Home 1348 Calhoun St. | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 3 1967 | | 25B. NAME OF REGISTRAR
P. E. F. F. | | 25C. ADDRESS
1348 Calhoun St. | |



BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

NELLIE BASKERVILLE

2. DATE AND HOUR PRONOUNCED DEAD

4-29-67

1100 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

608 N. PULASKI ST.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MARYLAND

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

BALTIMORE

16-05

D. STREET ADDRESS (If rural, give location)

608 N. PULASKI ST.

5. SEX

FEMALE

6. RACE

NEGRO

7. MARRIED, NEVER MARRIED

WIDOWED, DIVORCED (specify)
widowed

8. DATE OF BIRTH

8-7-09

9. AGE (In years
last birthday)

57

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

N.C.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

James McLenden

14. MOTHER'S MAIDEN NAME

Harriette

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Elizabeth Bradley 608 Pulaski St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

ARTERIOSCLEROTIC CARDIOVASCULAR
DISEASE

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT NOT WHILE
WORK AT WORK

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4-30-67

23A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

23C. NAME of CEMETERY or CREMATORY

23D. LOCATION

(City, town, or county)

(State)

Burial

5-4-67

Arbutus Mem. Pk.

Arbutus

Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

Kelson Funeral Home 1348 Calhoun St.

MAY 3 1967

Philip E. Johnson

274

WALLACE BOWEN

QUALITY PAPER

1
B-260

67 4319

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

67 4319

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

SAMUEL BOOKER

2. DATE AND HOUR PRONOUNCED DEAD

5-1-67 3:25 AM M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

1411 Presstman Street - Amb. Crew #4

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1411 Presstman Street

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

3-14-06

9. AGE (In years
last birthday)

61

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Richard Booker

14. MOTHER'S MAIDEN NAME

Annie Archer

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Douglass Gould 2222 Mt. Royal Terrace

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) (Min.)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)

WERNER U. SPITZ, M.D.

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

5-1-67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

5-1-67

23C. NAME OF CEMETERY or CREMATORY

Mt. Auburn Cem

23D. LOCATION

Balto.

(City, town, or county)

Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

MAY 3 1967

24B. NAME OF REGISTRAR

Robert E. Farkas

24C. FUNERAL DIRECTOR

Kelson Funeral Home 1348 Calhoun St.

ADDRESS

WALDEN POLICE

7/1/1911

1
m-520

| BALTIMORE CITY HEALTH DEPARTMENT | | | |
|--|-------------------------|--|--|
| BIRTH NO. 67 4320 | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 4320 | |
| M.E. CASE NO. | | | |
| 1. NAME OF DECEASED
(Type or Print) ANNIE MANN'S | | 2. DATE AND HOUR PRONOUNCED DEAD
4-29-67 1:20 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
2656 FLORA ST. | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE 13-03
D. STREET ADDRESS (If rural, give location) 2656 FLORA ST. | |
| 5. SEX
FEMALE | 6. RACE
NEGRO | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
widowed | 8. DATE OF BIRTH
8-3-92 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | 9. AGE (In years last birthday) 74 |
| 11. BIRTHPLACE (State or foreign country)
Md. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
John Walker | | 14. MOTHER'S MAIDEN NAME | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS
Margaret Manns 2656 Flora St. |
| 18. 422.1 I
CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | INTERVAL BETWEEN ONSET AND DEATH |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
[Signature]
EXAMINER'S NAME (Type) | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| 23A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 23B. DATE
5-3-67 | 23C. NAME OF CEMETERY or CREMATORY
Mt. Auburn Cem. |
| 23D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | | 24C. FUNERAL DIRECTOR ADDRESS
Kelson Funeral Home 1348 Calhoun St. | |
| 24A. DATE REC'D BY HEALTH DEPT.
MAY 3 1967 | | 24B. NAME OF REGISTRAR
[Signature] | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 4321 | |
|--|--|---|--|---|---|
| <div style="display: flex; justify-content: space-between;"> H-560 BIRTH NO. 67 4321 </div> | | | | | |
| M.E. CASE NO.
1. NAME OF DECEASED
(Type or Print) James Henry | | | 2. DATE AND HOUR OF DEATH
4-28-67 M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

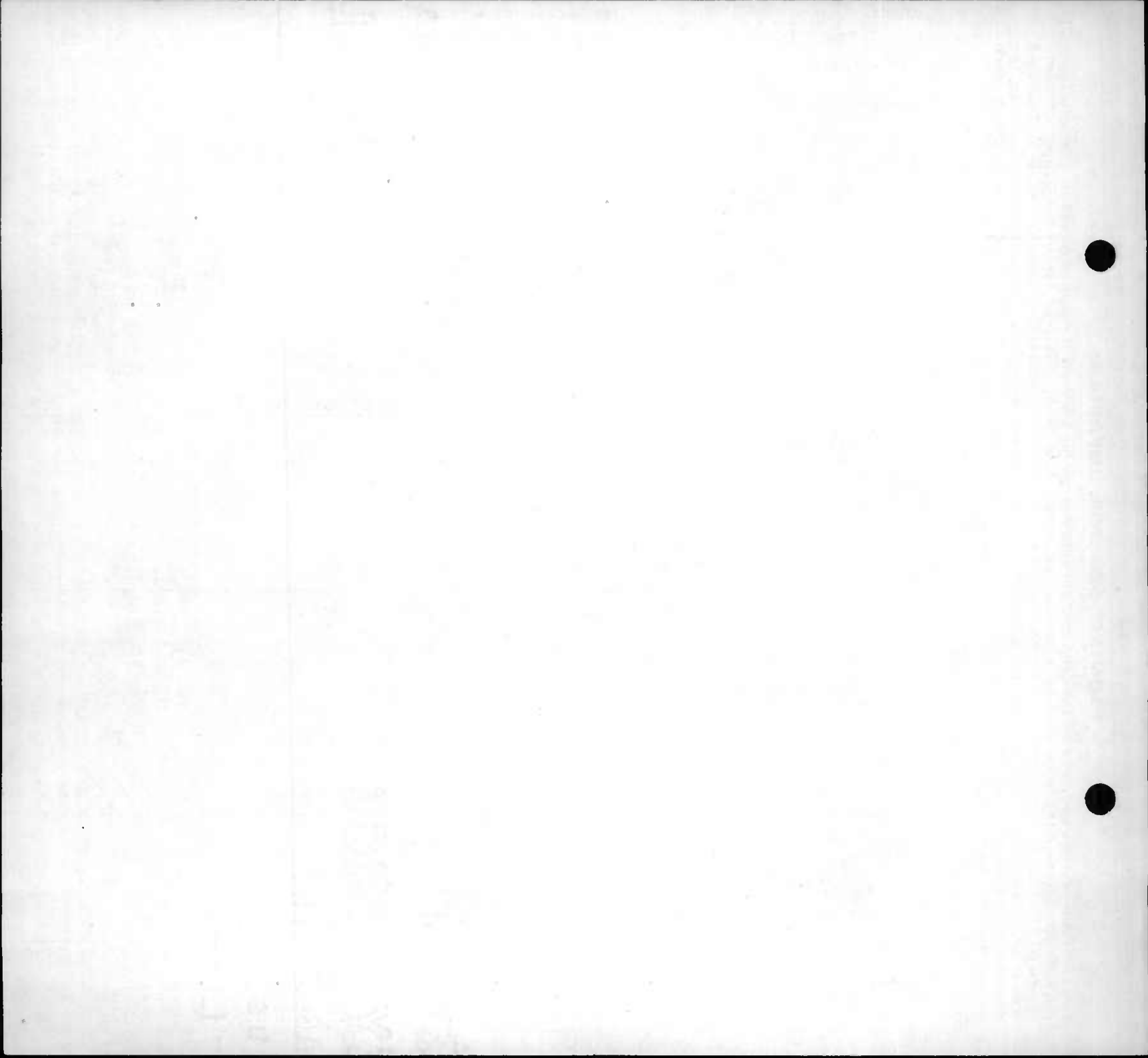
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
00 1123 Poplar Grove St. | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE Md.
B. COUNTY

C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Balto.
D. STREET ADDRESS (If rural, give location)
1123 Poplar Grove /St. | | |
| 5. SEX
Male | 6. RACE
Negroid | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
married | 8. DATE OF BIRTH
8-16-92 | 9. AGE (In years last birthday)
74 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
S.C. | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A | | | | | |
| 13. FATHER'S NAME
Jake Henry | | | 14. MOTHER'S MAIDEN NAME
Mary McClod | | |
| 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
247161642 | | 17. INFORMANT ADDRESS
Pauline Bixon 2828 Riggs Ave. | |
| <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
 (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

 ANTECEDENT CAUSES
 DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. </div> <div style="width: 45%;"> CAUSE OF DEATH
 (A) Hypertensive Cardiovascular Heart Disease
 (B)
 (C)

 INTERVAL BETWEEN ONSET AND DEATH
 one year </div> </div> | | | | | |
| <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> II
 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. </div> <div style="width: 45%;"> Coronary Insufficiency </div> </div> | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 4/27/1966 to 4/27/1967 , that (I) (we) last saw the deceased alive on 4/27/1967 and that in (my) (our) opinion death occurred on the date 4/27/1967 and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Odum N. Coker | | | 23B. DATE SIGNED
5/1/67 | | 23C. PHYSICIAN'S NAME (Type)
ODOM N. COKER |
| 23D. ADDRESS
3701 Liberty Hts Ave, Balto. Md. | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
5-2-67 | | 24C. NAME OF CEMETERY or CREMATORY
Mt. Auburn Cem. | |
| 24D. LOCATION (City, town, or county) (State)
Balto. Md. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 3 1967 | | 25B. NAME OF REGISTRAR
Robert E. Farley | | 25C. FUNERAL DIRECTOR ADDRESS
Kelson Funeral Home 1348 Calhoun St. | |

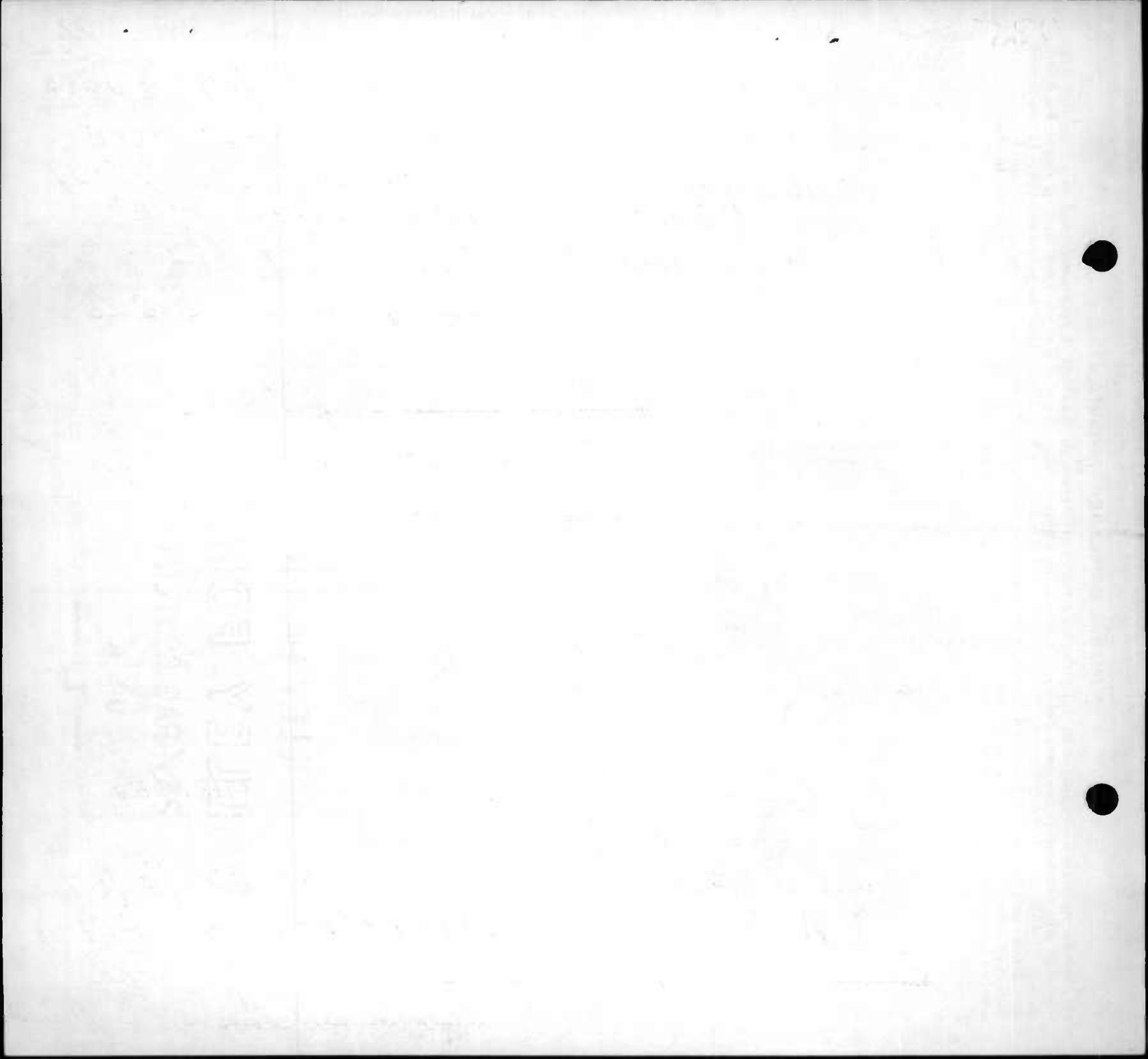
1 9 6 7 0 0 0 4 3 2 2



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67-4322 | |
|--|-----------|--|---------------------------|--|---|
| BIRTH NO. 67-4322 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) CLAYTON, SUSIE | | 2. DATE AND HOUR OF DEATH 4/30/67 5:20 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 425 SINAI HOSPITAL OF BALTIMORE | | A. STATE MARYLAND, BALTIMORE | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 15-09 | | | |
| | | D. STREET ADDRESS (If rural, give location) 4111 FAIRVIEW AVE | | | |
| 5. SEX F | 6. RACE N | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 11/15/12 | 9. AGE (In years last birthday) 54 | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME | | 14. MOTHER'S M maiden NAME | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 218320370 | | 17. INFORMANT Santee Clayton 4111 Fairview Ave | |
| 18. 153701 | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | (A) DUE TO HEPATOMA | | > 1 yr | |
| ANTECEDENT CAUSES | | (B) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) DUE TO | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 3/17/67 19 to 4/30/67 19, that (I) (we) last saw the deceased alive on 4/30/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Daniel A. Spott | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 4/30/67 | |
| 23C. PHYSICIAN'S NAME (Type) D.A. SPOTT | | 23D. ADDRESS M.D. SINAI HOSPITAL OF BALT | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 5-4-67 | | 24C. NAME OF CEMETERY or CREMATORY Balto. Nat'l. Cem. Balto. Md. | |
| 24D. LOCATION (City, town, or county) Balto. Md. | | 25A. DATE REC'D BY HEALTH DEPT. MAY 3 1967 | | 25B. NAME OF REGISTRAR Robert E. Jackson | |
| 25C. FUNERAL DIRECTOR Nelson Ferguson | | 25D. ADDRESS 1348 Calhoun | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 67 4323 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 4323 | |
|--|---------------------|---|--|--|---|
| M.E. CASE NO. | | | CERTIFICATE OF DEATH | | |
| 1. NAME OF DECEASED
(Type or Print) HENRIETTA E. SMITH | | | 2. DATE AND HOUR OF DEATH
5-2-67 4 45 A.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
42 SINAI HOSP. of BALTIMORE | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY BALTIMORE
C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE
D. STREET ADDRESS (If rural, give location) 1919 Kelley Ave #9 | | |
| 5. SEX
F | 6. RACE
N | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
M | 8. DATE OF BIRTH
10-23-95 | 9. AGE (In years last birthday)
71 | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Domestic | | 10B. KIND OF BUSINESS OR INDUSTRY
Laundry | | 11. BIRTHPLACE (State or foreign country)
BALTIMORE Md. | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | | 13. FATHER'S NAME
Albert Smith | | |
| 14. MOTHER'S MAIDEN NAME
Savilla Scott | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
215-54-0997 | | |
| 16. SOCIAL SECURITY NO.
215-54-0997 | | | 17. INFORMANT
Sylvester Smith- 1919 Kelly Ave. | | |
| 18. 422.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ASCVD. CVA
Hyperthyroidism
ASCVD. | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 4-4 19 67 to 5-2 19 67 , that (I) (we) last saw the deceased alive on 5-2 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Leslie Abramowitz | | | | 23B. DATE SIGNED
5-2-67 | |
| 23C. PHYSICIAN'S NAME (Type)
Leslie Abramowitz | | | | 23D. ADDRESS
SINAI HOSP. of BALTIMORE | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
5/6/67 | | 24C. NAME of CEMETERY or CREMATORY
Arbutus Memorial Park | |
| 24D. LOCATION (City, town, or county)
Baltimore Co. Maryland | | 25A. DATE REC'D BY HEALTH DEPT.
MAY 3 1967 | | | |
| 25B. NAME OF REGISTRAR
Robert E. Taylor | | 25C. FUNERAL DIRECTOR
Herbert E. Nutter -3035 W. North Ave. | | | |

Handwritten: 2-2-67

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 4324 | |
|---|----------------------|---|---------------------------------|--|--|
| BIRTH NO. 67 4324 | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <i>George Robert Johnson</i> | | | |
| 2. DATE AND HOUR OF DEATH | | <i>5/3/67 11:10 A.M.</i> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>Union Mem. Hosp.</i> | | A. STATE <i>Md</i> B. COUNTY <i>Balt</i> | | | |
| C. CITY OR TOWN <i>Balt</i> | | D. STREET ADDRESS (If rural, give location) <i>2459 Brentwood Ave</i> | | | |
| 5. SEX <i>M</i> | 6. RACE <i>negro</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <i>single</i> | 8. DATE OF BIRTH <i>6/21/09</i> | 9. AGE (In years last birthday) <i>57</i> | 10. AGE (In years last birthday) <i>57</i> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Porter</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>Porter</i> | | 11. BIRTHPLACE (State or foreign country) <i>Md</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>US</i> | | 13. FATHER'S NAME <i>Nelson Johnson</i> | | 14. MOTHER'S MAIDEN NAME <i>Josephine Thomas</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give year or dates of service) | | 16. SOCIAL SECURITY NO. <i>218-07-7810</i> | | 17. INFORMANT'S NAME AND ADDRESS <i>Mrs. Lucy Bond 2459 Brentwood Ave.</i> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | (A) DUE TO <i>Intra Cranial Bleeding</i> | | | |
| ANTECEDENT CAUSES | | (B) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) DUE TO | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>NO</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>4/11</i> 19 <i>67</i> to <i>5/2</i> 19 <i>67</i> that (I) (we) last saw the deceased alive on <i>5/2</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Robert P. Doyle</i> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <i>5/2/67</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>Robert P. Doyle</i> | | 23D. ADDRESS <i>Union Mem. Hosp.</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i> | | 24B. DATE <i>5/6/67</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>Arbutus Mem. Park</i> | |
| 24D. LOCATION (City, town, or county) <i>Baltimore Co. Md</i> | | 24E. STATE <i>Md</i> | | 24F. ADDRESS <i>3035 W. North Ave</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>MAY 3 1967</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Farley</i> | | 25C. FUNERAL DIRECTOR <i>Herbert E. Natter</i> | |

George Robert Johnson
Miss Mary Hop
and Galt
2/2/07

Mr. George Johnson
and Galt
2/2/07
27
20
Josephine Thomas

John Charles Johnson

Miss Mary Hop
2/2/07
2/2/07
2/2/07

Robert P. Doyle
George P. Doyle
2/2/07

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|---|------------------|--|--|---|--|--|---|
| M-4610 | | BIRTH NO. 67 4325 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 4325 | |
| M.E. CASE NO. | | | | 2. DATE AND HOUR OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) ANTOINETTE MILLER | | | | 5/2/1967 3 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
2228 EASTERN AVE | | | | A. STATE MARYLAND
B. COUNTY BALTIMORE
C. CITY OR TOWN (If outside city limits, write RURAL and give township) 1-05
D. STREET ADDRESS (If rural, give location) 2228 EASTERN AVE. | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) WIDOW | 8. DATE OF BIRTH 5-31-1892 | 9. AGE (In years last birthday) 74 | If Under 1 Yr. Months: Days: Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10B. KIND OF BUSINESS OR INDUSTRY GROCERY | | 11. BIRTHPLACE (State or foreign country) POLAND | | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME WALTER CHOJNOWSKI | | | | 14. MOTHER'S MAIDEN NAME FRANCES LEONARD | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. 215-34-7486 | | 17. INFORMANT LILLIAN KENDZEJESKI ADDRESS 2228 EASTERN AVE | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
422.11-199.2 | | | | CAUSE OF DEATH
(A) DUE TO Atherosclerosis (CVI) | | INTERVAL BETWEEN ONSET AND DEATH
10 yrs - | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) DUE TO | | | |
| (C) DUE TO | | | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | Generalized Circumotoria | | 3 mos | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1960 19 to 5-2-67 19, that (I) (we) last saw the deceased alive on 5-1-67 19 and that (n(my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Theodore T. Niznik M.D. | | | | | | 23B. DATE SIGNED 5-2-67 | |
| 23C. PHYSICIAN'S NAME (Type) T. T. NIZNIK M.D. | | | | 23D. ADDRESS 429 S. Chester | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 5/6/1967 | | 24C. NAME OF CEMETERY or CREMATORY HOLY ROSARY CEMETERY BALTO. | | 24D. LOCATION (City, town, or county) (State) MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT. MAY 3 1967 | | 25B. NAME OF REGISTRAR John M. Weber | | 25C. FUNERAL DIRECTOR JOHN M. WEBER & SONS INC. 401 S. CHESTER ST. | | | |

NY 4921-12-7

1
E. 554

67 4326

BALTIMORE CITY HEALTH DEPARTMENT

67 4326

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ROBERT

EMANUEL *SR*

2. DATE AND HOUR PRONOUNCED DEAD

5-1-67

12:30 PM M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

34 BON SECOUR HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2000 Christian Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

October 7, 1900

9. AGE (In years
last birthday)

66

If Under 1 Yr. If Under 24 Hrs.
Months, Days, Hours, Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Usher

10B. KIND OF BUSINESS OR INDUSTRY

THEATER

11. BIRTHPLACE (State or foreign country)

MINNESOTA

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

SOLOMON EMANUEL

14. MOTHER'S MAIDEN NAME

MARTHA ISAACS

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

NONE

16. SOCIAL
SECURITY NO.

213-16-4940

17. INFORMANT

ADDRESS

KATHERINE EMANUEL 2000 Christian St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) *Bilateral bronchopneumonia and pleurisy*

DUE TO

XXXX

complicating overdose of Darvon compound

(B) *DUE TO*

(C) *DUE TO*

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Partial

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Home

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

2000 Christian Street

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)
4 25 '67 ?

21E. INJURY OCCURRED

WHILE AT
WORK ☐

NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Ingested overdose of Darvon compound

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D. ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

5-1-67

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

5-4-67

23C. NAME OF CEMETERY OR CREMATORY

MORELAND MEMORIAL

23D. LOCATION

(City, town, or county)

(State)

BALTO COUNTY MD.

24A. DATE REC'D BY HEALTH DEPT.

MAY 3 1967

24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

*Geo. L. Schwab Funeral Home
Francis W. Miller 2101 Frederick Ave.*

WALLACE HODGINS

WALLACE HODGINS

WALLACE HODGINS

WALLACE HODGINS

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WALLACE HODGINS

WALLACE HODGINS

WALLACE HODGINS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 4327 | |
|--|---|---|--|--|---|
| CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. 67 4327 | | | | | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED
(Type or Print) MAGDELENA (LENA) MADELINE JONES | | 2. DATE AND HOUR OF DEATH
APRIL 30, 1967 10:20 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)
A. STATE MARYLAND B. COUNTY 28-02 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
5117 Liberty Heights Ave. | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE | | | |
| | | D. STREET ADDRESS (If rural, give location)
5117 Liberty Heights Ave. | | | |
| 5. SEX
FEMALE | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
widowed | 8. DATE OF BIRTH
DEC. 10, 1884 | 9. AGE (in years last birthday)
82 | 10. Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY
Domestic | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
Charles Hasse | | 14. MOTHER'S MAIDEN NAME
Hannie Gunther | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
213-54-3467 | | 17. INFORMANT
Frank Jones | |
| 18. 4-22-11
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Cerebral Hemorrhage | | CAUSE OF DEATH
ASCVD | | INTERVAL BETWEEN ONSET AND DEATH
10 min | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating UNDERLYING CONDITION last.
? | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At <input type="checkbox"/> Work | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 8-6-66 19 59 to 4-30 19 67 , that (I) (we) last saw the deceased alive on Nov 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Earl Pass | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
5-1-67 | |
| 23C. PHYSICIAN'S NAME (Type)
EARL PASS | | 23D. ADDRESS
401 Wilkes Ave Baltimore | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
5-4-67 | | 24C. NAME OF CEMETERY OR CREMATORY
London Park | |
| 24D. LOCATION (City, town, or county) (State)
BALTIMORE, MD. | | 25A. DATE REC'D BY HEALTH DEPT.
MAY 3 1967 | | | |
| 25B. NAME OF REGISTRAR
Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR
GEO. L. Schwab FUNERAL HOME | | | |
| 25D. ADDRESS
Francis St. Yellow 2101 Franklin Ave. | | | | | |

Handwritten text, mostly illegible due to blurriness and bleed-through. Visible fragments include:

- Top section: Faint, mostly illegible handwriting.
- Middle section: "Handwritten" (likely bleed-through from the reverse side).
- Bottom section: "Nov 8-94" (likely bleed-through from the reverse side).
- Bottom right: "Faint handwritten text" (likely bleed-through from the reverse side).

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 67 4328 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 4328 | |
|---|-----------|--|-----------------------------------|---|---|--|------------------------------|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) | | | | 2. DATE AND HOUR OF DEATH | | | |
| FRAZIER, FLEM LAFAYETTE, JR. | | | | MAY 2, 1967 6:50AM M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF INSTITUTION (If not in hospital or institution, give street address or location) | | | | A. STATE B. COUNTY | | | |
| ST. AGNES HOSPITAL
WILKENS & CATON AVES.
BALTO. 29, MD. | | | | MD. 2005 | | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | | BALTIMORE #23 | | | |
| D. STREET ADDRESS (If rural, give location) | | | | 2200 WILKENS AVE. | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min. | |
| MALE | CAUCASION | MARRIED | 02-22-93 | 74 | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? |
| RETIRED MINER | | | COAL MINING UNKNOWN | | KENTUCKY | | U.S.A. |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| JAMES FRAZIER | | | | JULIA BURCHETT | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | |
| NO NONE | | | 403-05-1491 | | ST. AGNES RECORDS: WILKENS & CATON AVES. | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| PULMONARY EMBOLISM, MULTIPLE. | | | | | | 1 DAY | |
| ANTECEDENT CAUSES | | | | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | C. CARCINOMA OF COLON | | APPROX. 3 MONTHS | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 34/25/67 | | COLON CARCINOMA OF - | | YES | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from APRIL 7 19 67 to APRIL MAY 2 19 67, that (I) (we) last saw the deceased alive on MAY 2 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | | |
| Thamnoon Penroach M.D. | | | | 5/2/67 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| THAMNOON PENROACH M.D. | | | | CATON & WILKENS AVE. BALTIMORE MD | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| BURIAL | | 5-5-67 | | MT. OLIVET | | BALTIMORE, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | | | |
| MAY 3 1967 | | Geo. L. Schwartz | | Funeral Home 2101 Frederick Ave. | | | |

DATE: 1944, 11/11/44

TO: SAC, NEW YORK
FROM: SAC, NEW YORK

RE: [illegible]

DATE: 11-11-44

TO: SAC, NEW YORK

FROM: SAC, NEW YORK

RE: [illegible]

DATE: 11-11-44

TO: SAC, NEW YORK

FROM: SAC, NEW YORK

TO: SAC, NEW YORK

FROM: SAC, NEW YORK

W. 500

67 4329

BALTIMORE CITY HEALTH DEPARTMENT

67 4329

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JOSEPH WIN

2. DATE AND HOUR PRONOUNCED DEAD

April 28, 1967

8:20 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

39 Provident Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2022 W. Lanvale Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Infant

8. DATE OF BIRTH

11/5/64

9. AGE (In years
last birthday)

2

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Child

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore Maryland

12. CITIZEN OF
WHAT COUNTRY?

U S A

13. FATHER'S NAME

Joseph Wynn, Sr

14. MOTHER'S MAIDEN NAME

Bernadette Nutt

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

17. INFORMANT

Mother

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) Acute bronchitis and bronchiolitis
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Sickle cell disease (S-C hemoglobin)

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT NOT WHILE
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion

resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

April 28, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

5/1/67

23C. NAME OF CEMETERY or CREMATORY

New Cathedral Cemetery

23D. LOCATION

Baltimore Md

24A. DATE REC'D BY HEALTH DEPT.

MAY 3 1967

24B. NAME OF REGISTRAR

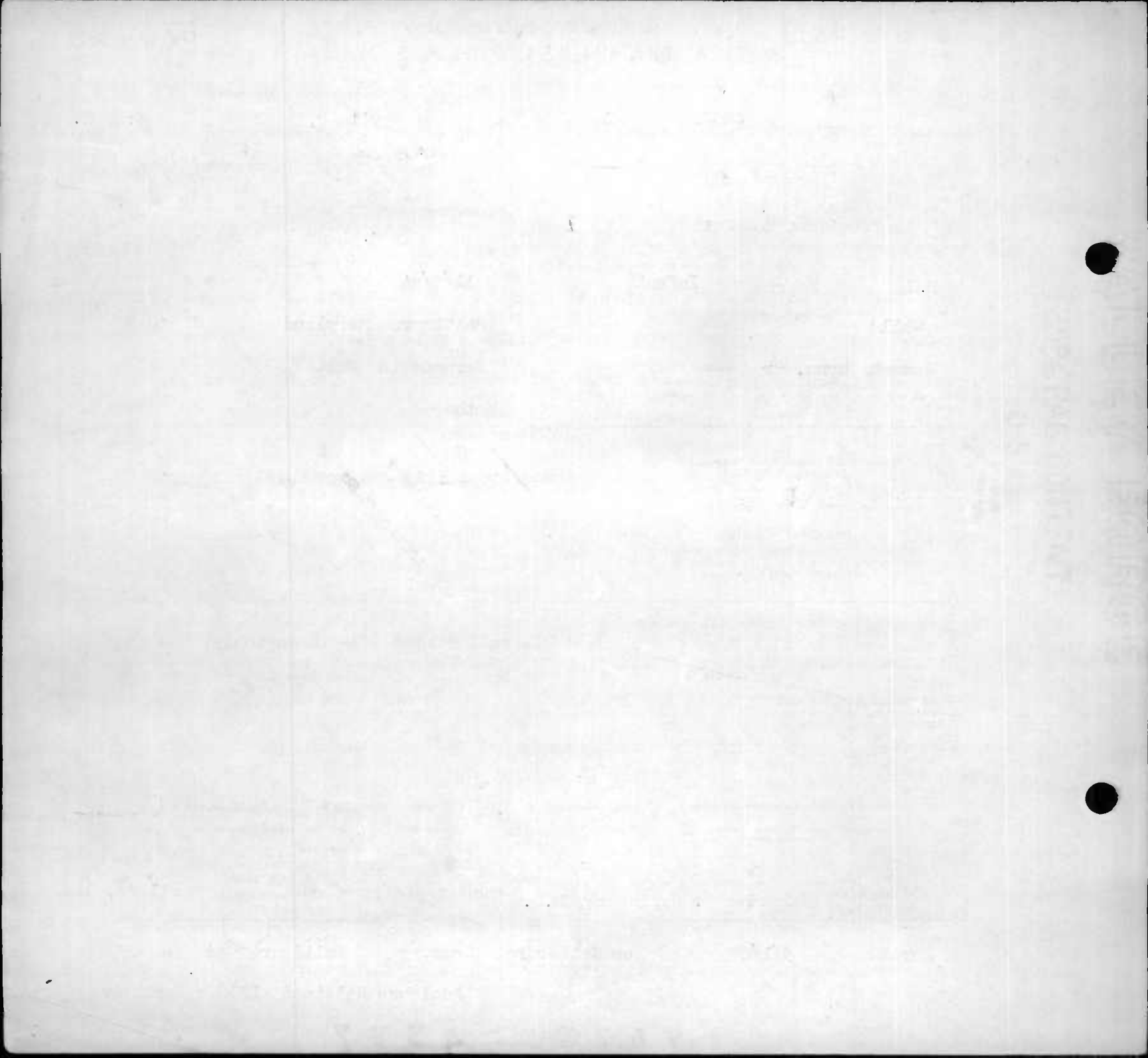
Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

Adolphus Halstead 1206 W North Ave

ADDRESS

1 2 6 7 0 0 0 4 3 3 7



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | | | | | | |
|--|--|----------------------|--|---|--|---------------------------------|--|---|--|--|--|------------------------------|--|--|--|--|
| BIRTH NO. 67 4330 | | | | | CERTIFICATE OF DEATH | | | | | Registered No. 67 4330 | | | | | | |
| M.E. CASE NO. | | | | | 1. NAME OF DECEASED (Type or Print) <i>Green, Levi Lawrence (or)</i> | | | | | 2. DATE AND HOUR OF DEATH <i>4/30/1967 9:35 P.M.</i> | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE <i>MARYLAND</i>
B. COUNTY | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE, 31</i> | | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<i>33 JOHNS HOPKINS HOSPITAL.</i> | | | | | D. STREET ADDRESS (If rural, give location)
<i>207 N. DALLAS CT.</i> | | | | | | | | | | | |
| 5. SEX <i>MALE</i> | | 6. RACE <i>NEGRO</i> | | 7. MARRIED, NEVER MARRIED
<i>WIDOWED, DIVORCED (specify)</i>
<i>MARRIED</i> | | 8. DATE OF BIRTH <i>8-15-09</i> | | 9. AGE (In years last birthday) <i>57</i> | | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Hours: Min. | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Lunchroomman</i> | | | | | 10B. KIND OF BUSINESS OR INDUSTRY
<i>Steamship Co.</i> | | | | | 11. BIRTHPLACE (State or foreign country)
<i>Schulerville, S.C.</i> | | | | | 12. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | |
| 13. FATHER'S NAME
<i>SAM GREEN</i> | | | | | 14. MOTHER'S MAIDEN NAME
<i>ANNIE THOMAS</i> | | | | | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>No</i> | | | | | 16. SOCIAL SECURITY NO.
<i>217-07-4216</i> | | | | | 17. INFORMANT
<i>Ida Green 207 N. Dallas Ct.</i> | | | | | ADDRESS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
<i>162.1 I</i>
<i>Branhogenic Ca.</i> | | | | | CAUSE OF DEATH
(A) DUE TO
(B) DUE TO
(C) DUE TO | | | | | INTERVAL BETWEEN ONSET AND DEATH
<i>> 5 yrs</i> | | | | | | |
| 18. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | | | | | | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | | | | | | |
| 19A. DATE OF OPERATION | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20A. AUTOPSY? (Yes or No)
<i>NO</i> | | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | 21F. HOW DID INJURY OCCUR? | | | | | | |
| 22. I certify that (1) (this hospital) attended the deceased from <i>4/29</i> to <i>4/30</i> 19 <i>67</i> and that (2) (we) last saw the deceased alive on <i>4/30</i> 19 <i>67</i> and that in (3) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | |
| 23A. SIGNATURE
<i>Sherrard L. Hayes</i> | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | | 23B. DATE SIGNED
<i>4/30/67</i> | | | | | | |
| 23C. PHYSICIAN'S NAME (Type)
<i>SHERRARD L. HAYES</i> | | | | | 23D. ADDRESS
<i>THE JOHNS HOPKINS HOSPITAL</i> | | | | | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | | | | | 24B. DATE
<i>4-4-67</i> | | | | | 24C. NAME OF CEMETERY OR CREMATORY
<i>Mt Calvary Cemetery</i> | | | | | 24D. LOCATION (City, town, or county) (State)
<i>Anne Arundel Co. Md.</i> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<i>MAY 3 1967</i> | | | | | 25B. NAME OF REGISTRAR
<i>Robert E. Farber, M.D.</i> | | | | | 25C. FUNERAL DIRECTOR
<i>Randolph J. Collick</i> | | | | | ADDRESS
<i>243 E. Oliver St.</i> | |

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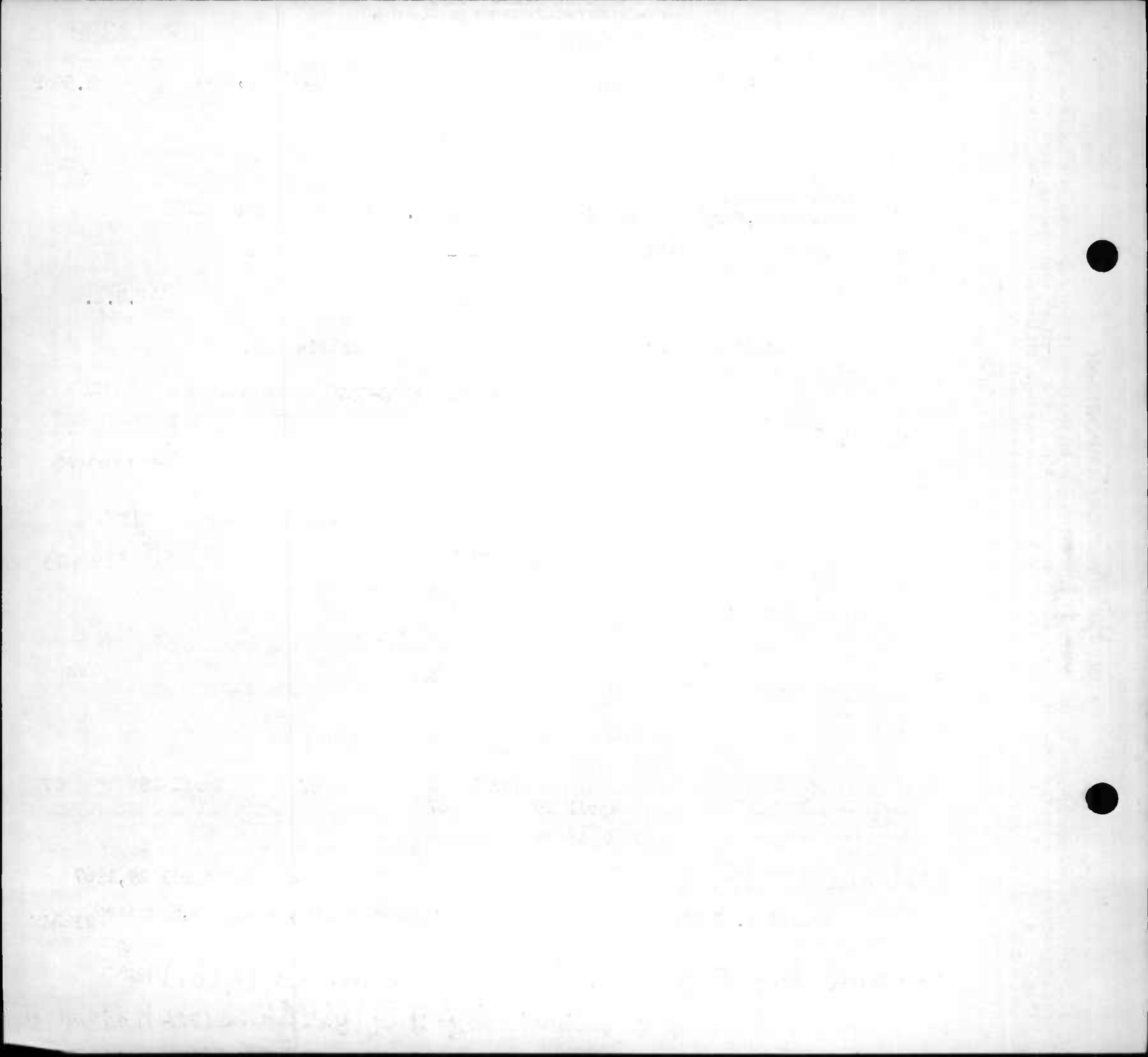
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 67 4331 | | BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | Registered No. 67 4331 | |
|---|-----------------------------|---|------------------------------------|---|------------------------------|
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) GEORGE CHARLES PFAFFSR | | 2. DATE AND HOUR OF DEATH
5/2/67 2 A M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE MD B. COUNTY Baltimore City | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore 27-12 | |
| FULL NAME OF HOSPITAL OR INSTITUTION
Union Memorial Hospital | | D. STREET ADDRESS (If rural, give location)
5416 Purlington Way | | E. STREET ADDRESS (If rural, give location) | |
| 5. SEX
M | 6. RACE
Caucasian | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH
9/30/93 | 9. AGE (In years, last birthday)
73 | 10. Under 1 Yr. Months: Days |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired - ENG. MECH. | | 10B. KIND OF BUSINESS OR INDUSTRY
KOPPERS CO. | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 13. FATHER'S NAME
George John PFAFF | | 14. MOTHER'S MAIDEN NAME
MARY Elizabeth Schmidt | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
212-079835 | | 17. INFORMANT
Mrs. Cecelia PFAFF | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
BILATERAL CONFLUENT PNEUMONIA (ACUTE) | | CAUSE OF DEATH
(A) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH
STATUS POST RESECTION OF ABDOMINAL AORTA | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO | | (C) DUE TO | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
4/24/67 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
Aortic Aneurysm | | 20A. AUTOPSY? (Yes or No)
YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) <u>this hospital</u> attended the deceased from 4/24 19 67 to 5/2 19 67 , that (1) <u>we</u> last saw the deceased alive on 5/2 19 67 and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above. (1) <u>We</u> (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Charles H. Classen Jr. | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
5/2/67 | |
| 23C. PHYSICIAN'S NAME (Type)
CHARLES H. CLASSEN JR., M.D. | | 23D. ADDRESS
THE UNION MEMORIAL HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
5/4/1967 | | 24C. NAME of CEMETERY or CREMATORY
Baltimore, Maryland | |
| 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | | 25A. DATE REC'D BY HEALTH DEPT.
MAY 3 1967 | | | |
| 25B. NAME OF REGISTRAR
Robert E. Farley | | 25C. FUNERAL DIRECTOR
H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md. | | | |

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

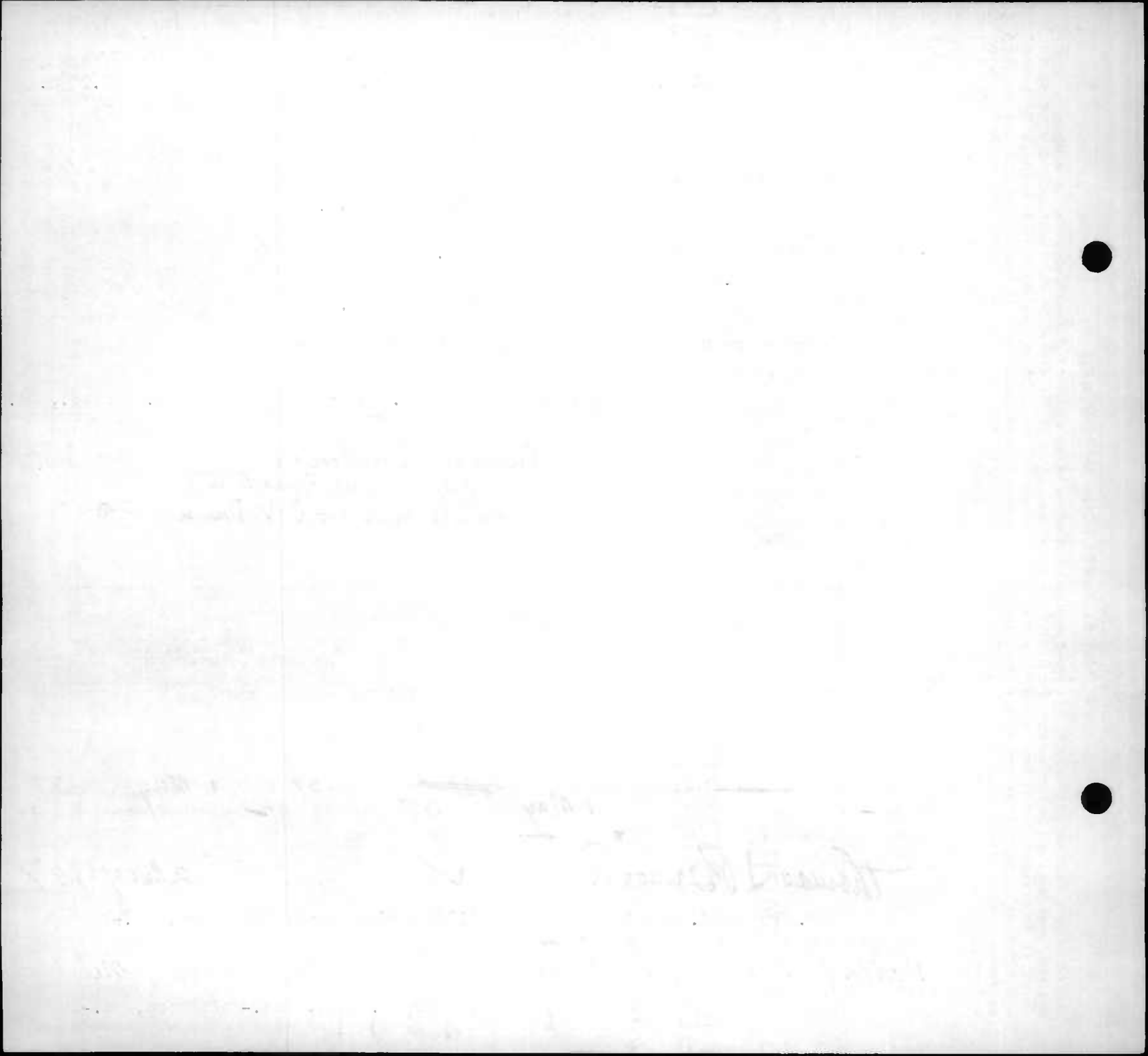
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>67 4332</u> | |
|--|-------------------------|--|-------------------------------------|--|--|
| BIRTH NO. <u>67 4332</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) <u>William Anderson</u> | | 2. DATE AND HOUR OF DEATH
<u>April 29, 1967</u> <u>2.50 P.M.</u> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>Baltimore City Hospitals</u>
<u>4940 Eastern Avenue</u>
<u>Baltimore, Maryland 21224</u> | | A. STATE <u>Maryland</u>
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>
D. STREET ADDRESS (If rural, give location) <u>208 N. Montford Avenue 21213</u> | | | |
| 5. SEX
<u>Male</u> | 6. RACE
<u>Negro</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
<u>Single</u> | 8. DATE OF BIRTH
<u>5-5-1888</u> | 9. AGE (In years last birthday) <u>78</u> | 10. If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>Virginia</u> | |
| 13. FATHER'S NAME
<u>William Anderson</u> | | 14. MOTHER'S MAIDEN NAME
<u>Sallie</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
<u>Records: BCH-4940 Eastern Avenue 21224</u> | |
| 18. <u>606X I</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) <u>SEPSIS</u>
DUE TO <u>PERFORATED ULCUS</u>
(B) <u>VESICO-ENTERIC FISTULA</u>
DUE TO
(C) <u>CVA</u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>36 Hours</u>
<u>yes</u>
<u>48 Hours</u> | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
<u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<u>Yes</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>April 8</u> 19 <u>67</u> to <u>April 29</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>April 29</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>Daniel D. Foote</u> | | | | 23B. DATE SIGNED
<u>April 29, 1967</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>Daniel D. Foote</u> | | | | 23D. ADDRESS
<u>4940 Eastern Avenue, Baltimore, Maryland 21224</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE
<u>May 5/67</u> | | 24C. NAME OF CEMETERY or CREMATORY
<u>Int Calvary Am. A. C. Md</u> | |
| 24D. LOCATION (City, town, or county) (State) | | 25A. DATE REC'D BY HEALTH DEPT
<u>MAY 3 1967</u> | | | |
| 25B. NAME OF REGISTRAR
<u>Robert E. Williams</u> | | 25C. FUNERAL DIRECTOR
<u>1701 N Bend H</u> | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 67 4333 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 4333 | |
|--|------------------|---|--|---|------------------------------------|--|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) THERESA K. HUBER | | | | 2. DATE AND HOUR OF DEATH
May 1, 1967 | | 11.20 p.m. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

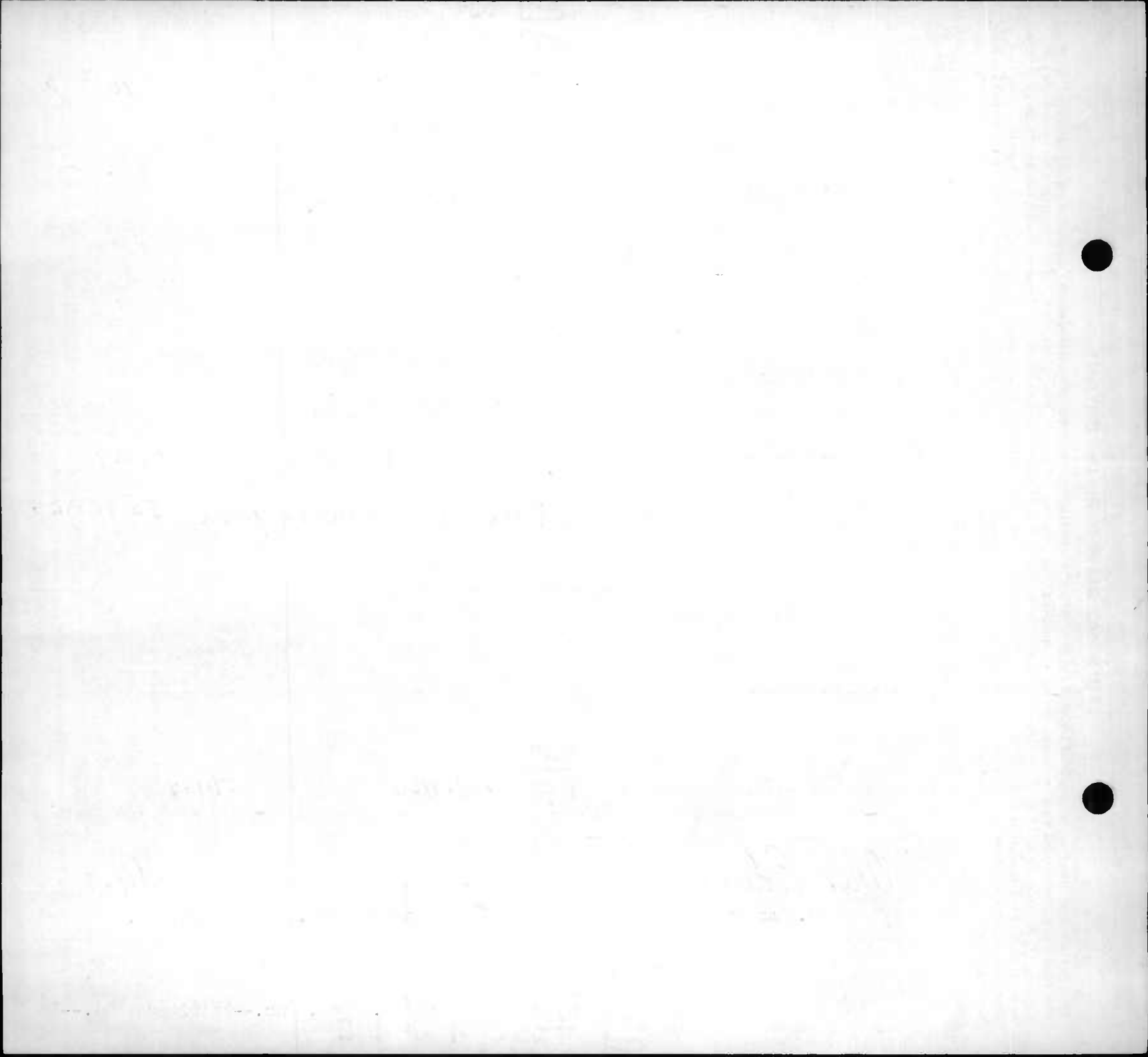
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
3617 White Avenue | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 3617 White Ave. | | | |
| 5. SEX
female | 6. RACE
white | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
married | | 8. DATE OF BIRTH
Sept. 6, 1907 | 9. AGE (In years last birthday) 59 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Jerome Krein | | | | 14. MOTHER'S MAIDEN NAME
Katherine Bowman | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
no | | 16. SOCIAL SECURITY NO.
NONE | | 17. INFORMANT
Edward J. Huber 3617 White Ave., Balto., Md. | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
420.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | CAUSE OF DEATH
(A) DUE TO
Coronary Thrombosis & Myocardial Infarction
(B) DUE TO
Atherosclerotic C.V. Disease
(C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH
30 minutes
20 yrs | |
| 19A. DATE OF OPERATION | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1959 to 1 May 1967, that (I) (we) last saw the deceased alive on 1 May 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (didn't) view the body after death. | | | | | | | |
| 23A. SIGNATURE
Thomas J. Brennan M.D. | | | | | | 23B. DATE SIGNED
2 May 1967 | |
| 23C. PHYSICIAN'S NAME (Type)
Dr. Thomas J. Brennan | | | | 23D. ADDRESS
5217 Harford Road, Baltimore, Md.-14 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
5/5/67 | | 24C. NAME OF CEMETERY or CREMATORY
Holy Redeemer Cem. | | 24D. LOCATION (City, town, or county) (State)
BALTIMORE, MD. | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 3 1967 | | 25B. NAME OF REGISTRAR
Robert E. Taylor | | 25C. FUNERAL DIRECTOR
Leonard J. Ruck, Inc.-Baltimore, Md.-14 | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. | |
|---|------------------|---|--|--|---|
| 67 4334 | | CERTIFICATE OF DEATH | | 67 4334 | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED
(Type or Print) KATHERINE T. SIMMS | | | 2. DATE AND HOUR OF DEATH
May 1, 1967 10 ³⁰ P.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
35 Church Home & Hospital | | | A. STATE
Maryland | | |
| (If not in hospital or institution, give street address or location) | | | B. COUNTY | | |
| | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore 21224 26-05 | | |
| | | | D. STREET ADDRESS (If rural, give location)
6823 Conley St. | | |
| 5. SEX
female | 6. RACE
white | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
married | 8. DATE OF BIRTH
Oct. 12, 1909 | 9. AGE (In years last birthday)
57 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
MARTIN Kelly | | 14. MOTHER'S MAIDEN NAME
KATHERINE BANNANHAN | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
MR. LAWRENCE L. SIMMS | |
| | | | | ADDRESS
(SAME) | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
443X I
MYOCARDIAL INFARCTION | | | INTERVAL BETWEEN ONSET AND DEATH
1 DAY | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (B) HYPERTENSIVE HEART DISEASE 15 YEARS | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 12/19/60 19 to 5/1/67 19, that (I) (we) last saw the deceased alive on 5/1/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Max Baum | | | | 23B. DATE SIGNED
5/2/67 | |
| 23C. PHYSICIAN'S NAME (Type) Dr. Max Baum | | | | 23D. ADDRESS
7422 Eastern Ave., Baltimore, Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
5/5/67 | | 24C. NAME OF CEMETERY or CREMATORY
NEW CATHEDRAL CEM. | |
| 24D. LOCATION (City, town, or county) (State)
BALTIMORE, MD. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 3 1967 | | 25B. NAME OF REGISTRAR
Robert E. Taylor | | 25C. FUNERAL DIRECTOR
Leonard J. Ruck, Inc.--Baltimore, Md.--14 | |



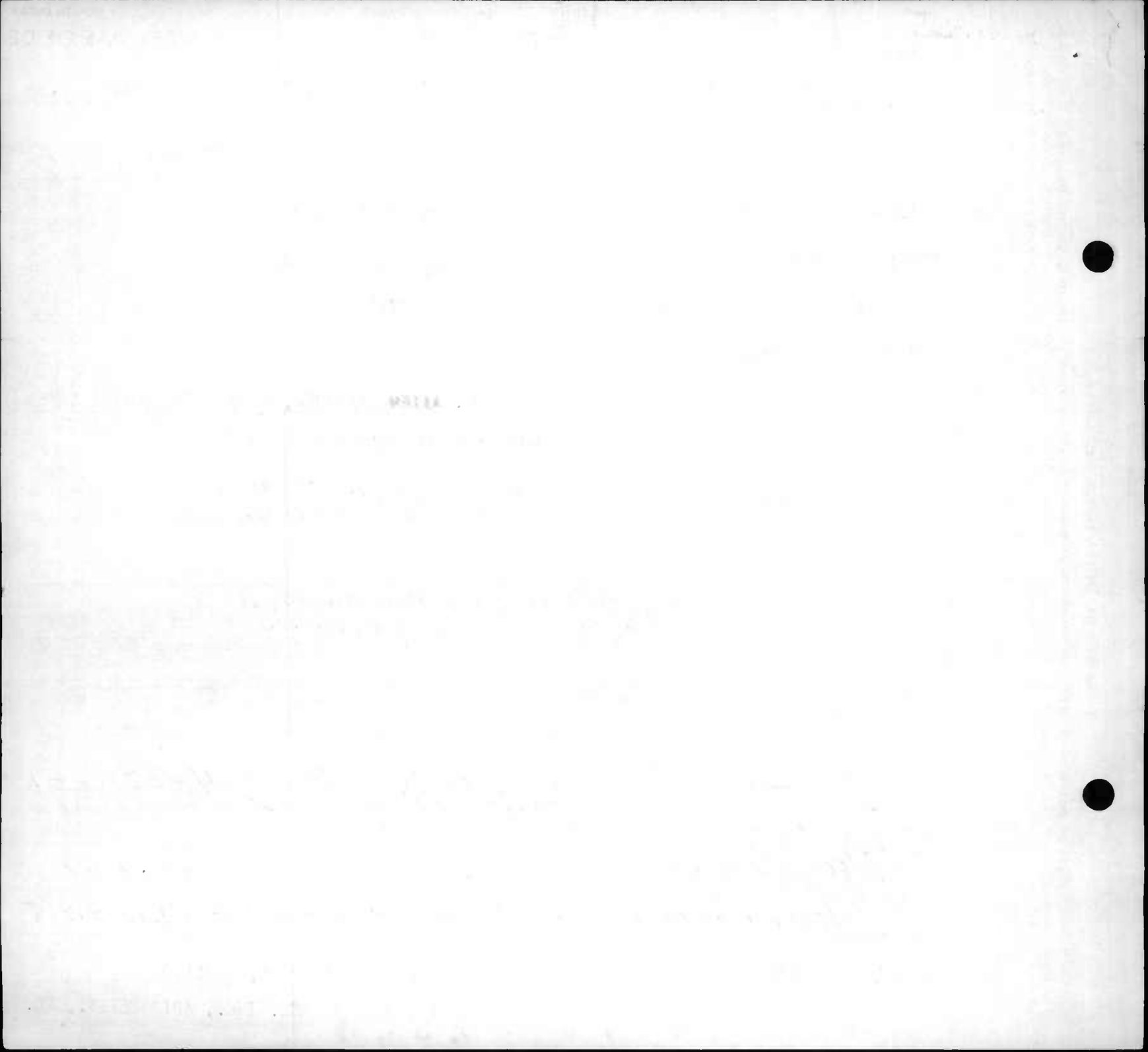
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 4335 | |
|---|----------------------|---|--------------------------------|--|---|
| BIRTH NO. 67 4335 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED RYLAND B. Butler R. Greenstreet | | 2. DATE AND HOUR OF DEATH 4/29/67 5:45 p. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND
CERTIFICATE AMENDED 5-9-67 | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE Maryland
B. COUNTY Baltimore
C. CITY OR TOWN (If outside city limits, write RURAL and give township) 25-04
D. STREET ADDRESS (If rural, give location) 3606 5th Street | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widower | 8. DATE OF BIRTH 9/5/91 | 9. AGE (In years last birthday) 75 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Virginia | |
| 13. FATHER'S NAME Philip P. Greenstreet | | 14. MOTHER'S MAIDEN NAME Martha | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no, unknown) (If yes, give war or dates of service) Yes | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Family ADDRESS Same | |
| 18. 753.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Antecedent Causes
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Aspirin overdose and Cardiac failure | | CAUSE OF DEATH
(A) Cerebro Vascular Embolism
DUE TO
(B) Atrial Fibrillation
DUE TO
(C)
INTERVAL BETWEEN ONSET AND DEATH
5 days
1-2 mos | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that the (this hospital) attended the deceased from 4/24/67 19 to 4/29/67 19, that we (we) last saw the deceased alive on 4/29/67 19 and that in our (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Rifat Abouley | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 5/1/67 | |
| 23C. PHYSICIAN'S NAME (Type) Rifat Abouley | | 23D. ADDRESS S.B.G.H. 1213 Light Street | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 5/4/67 | | 24C. NAME OF CEMETERY or CREMATORY Glen Haven Cem | |
| 24D. LOCATION (City, town, or county) Glen Burnie | | 24E. STATE Md | | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAY 3 1967 | | 25B. NAME OF REGISTRAR Robert E. [Signature] | | 25C. FUNERAL DIRECTOR McGully F H, 237 Patapsco Ave 21225 | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | | | Registered No. 67 4336 | |
|---|-------------------------|--|---|---|---|
| BIRTH NO. 67 4336 | | | | | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED
(Type or Print) THERESA SAFRANEK | | 2. DATE AND HOUR OF DEATH
APRIL 28, 1967 7:30 P. M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
BELVEDERE NURSING HOME | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE | | | |
| | | D. STREET ADDRESS (If rural, give location)
3005 GRANADA AVENUE | | | |
| 5. SEX
FEMALE | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
WIDOW | 8. DATE OF BIRTH
83 | 9. AGE (In years last birthday) | 10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWIFE |
| | | 10B. KIND OF BUSINESS OR INDUSTRY
AT HOME | 11. BIRTHPLACE (State or foreign country)
RUSSIA | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
? KASTEN | | 14. MOTHER'S MAIDEN NAME
UNKNOWN | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
UNKNOWN | 17. INFORMANT
ALFRED SAFRANEK, 8504 GLEN MICHAEL LANE | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)
Myocardial Infarction | | CAUSE OF DEATH
Arterio Sclerotic Cardiovascular Disease | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Generalized Arteriosclerosis & Severe Senile psychosis | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from April 19 60 to 4-28-19 67 , that (I) (we) last saw the deceased alive on 4-27-19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Joseph Deckerbaum M.D. | | | | 23B. DATE SIGNED
4-29-67 | |
| 23C. PHYSICIAN'S NAME (Type)
JOSEPH DECKERBAUM M.D. | | 23D. ADDRESS
3502 W. ROGERS AVE BALTO 21215 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
4/30/67 | | 24C. NAME OF CEMETERY or CREMATORY
TIFERETH ISRAEL ANSHE SPARD | |
| 24D. LOCATION (City, town, or county) (State)
BALTIMORE, MARYLAND | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 3 1967 | | 25B. NAME OF REGISTRAR
John E. Taylor | | 25C. FUNERAL DIRECTOR ADDRESS
SOL LEVINSON & BROS. INC., 6010 REIST., RD. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 4337 | |
|--|------------------|--|---------------------------------|--|--|
| BIRTH NO. 67 4337 | | CERTIFICATE OF DEATH | | M. 805 P | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) LENA (RODMAN) KAPLAN | | 2. DATE AND HOUR OF DEATH 4/27/67 | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | A. STATE MARYLAND | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSPITAL OF BALTIMORE | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | D. STREET ADDRESS (If rural, give location) 3402 ROYCE AVE | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WID | 8. DATE OF BIRTH 7/23/88 | 9. AGE (In years last birthday) 78 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY AT HOME | | 11. BIRTHPLACE (State or foreign country) RUSSIA | |
| 13. FATHER'S NAME FISHKIND | | 14. MOTHER'S MAIDEN NAME REBECCA | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 228-24-1762 | | 17. INFORMANT Chart, Hospital ADDRESS | |
| 18. 420.1 I | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | (A) MYO CARDIAL INFARCTION | | IMMEDIATE | |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | DUE TO ARTERIO SCLEROTIC HEART DISEASE | | AT LEAST | |
| ANTECEDENT CAUSES | | (B) CONGESTIVE HEART FAILURE | | 1 YR. | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 3/30/67 19 to 4/27 19 67 that (I) (we) lost saw the deceased alive on 4/27 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Sheldon Frank M.D. | | | | 23B. DATE SIGNED 4/27/67 | |
| 23C. PHYSICIAN'S NAME (Type) SHELDON FRANK M.D. | | | | 23D. ADDRESS SINAI HOSPITAL OF BALTIMORE | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 4/30/67 | | 24C. NAME OF CEMETERY or CREMATORY HEBREW YOUNG MEN | |
| 24D. LOCATION (City, town, or county) BALTIMORE, MARYLAND | | 24E. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS. INC., 6010 REIST., RD. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAY 3 1967 | | 25B. NAME OF REGISTRAR Robert E. Farber | | 25C. FUNERAL DIRECTOR ADDRESS | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | Registered No. 67 4338 | |
|---|--|---------------|--|---|--|---|--|
| BIRTH NO. 67 4338 | | M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) LEAH KLEIN | | 2. DATE AND HOUR OF DEATH
4/28/67 4 15 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
46 LUTHERAN HOSPITAL | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD B. COUNTY - | | | |
| 5. SEX FEMALE 6. RACE WHITE 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOW | | | | 8. DATE OF BIRTH 2/22/1896 9. AGE (In years last birthday) 71 | | 10. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | | 11B. KIND OF BUSINESS OR INDUSTRY at Home | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Pasqch | | | | 14. MOTHER'S MAIDEN NAME UNKNOWN | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | | 16. SOCIAL SECURITY NO. UNKNOWN | | 17. INFORMANT Mrs. Renee Mockler | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ACUTE MYOCARDIAL INFARCTION | | | | 19. CAUSE OF DEATH
(A) DUE TO ACUTE MYOCARDIAL INFARCTION | | 20. ADDRESS
3762 Gwynn Oak Ave | |
| 21. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
DIABETES MELLITUS | | | | 22. INTERVAL BETWEEN ONSET AND DEATH
HOURS | | 23. 30 YEARS. | |
| 24. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | 25. DATE OF OPERATION 0 | | 26. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 27. DATE OF OPERATION 0 | | | | 28. AUTOPSY? (Yes or No) NO | | 29. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 30. MEDICAL CERTIFICATION
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notably medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)
21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>
21F. HOW DID INJURY OCCUR? | | | | 31. I certify that (I) (this hospital) attended the deceased from 4/28 1967 to 4/28 1967 , that (I) (we) last saw the deceased alive on 4/28 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 32. SIGNATURE
Oscar E. Ferdinandini M.D. | | | | 33. DATE SIGNED
4/28/67 | | 34. ADDRESS
Lutheran Hospital | |
| 35. PHYSICIAN'S NAME (Type)
OSCAR E. FERNANDINI M.D. | | | | 36. ADDRESS
Lutheran Hospital | | | |
| 37. BURIAL CREMATION, REMOVAL (Specify)
Removal | | | | 38. DATE
4-28-67 | | 39. NAME OF CEMETERY OR CREMATORY
Prosevelt | |
| 40. LOCATION (City, town, or county) (State)
Bucks County - Pa. | | | | 41. DATE REC'D BY HEALTH DEPT.
MAY 3 1967 | | | |
| 42. NAME OF REGISTRAR
Robert E. Johnson | | | | 43. FUNERAL DIRECTOR
Schiffert's or + Bros. Inc. | | | |
| 44. ADDRESS
6010 Reisterstown Rd. | | | | 45. ADDRESS
6010 Reisterstown Rd. | | | |

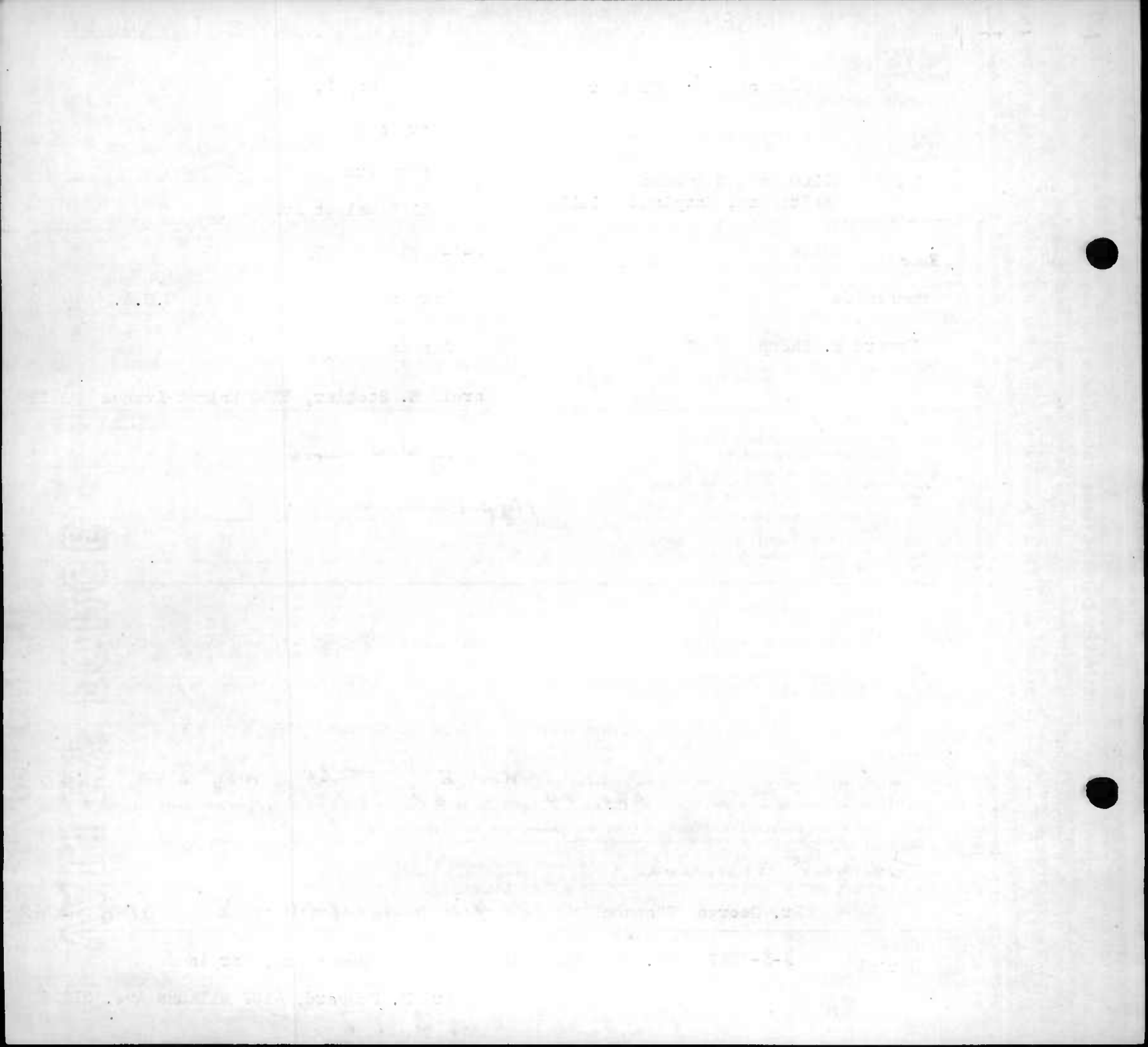
3102
Baltimore
Car Ave

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 4339 | |
|--|-------------------------|--|---|---|--|
| <div style="display: flex; justify-content: space-between;"> BIRTH NO. 67 4339 CERTIFICATE OF DEATH </div> | | | | | |
| M.E. CASE NO.
1. NAME OF DECEASED
(Type or Print) Beulah G. Stotler | | | 2. DATE AND HOUR OF DEATH
May 2, 1967 | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
1200 Walnut Avenue
Baltimore, Maryland 21229 | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Baltimore
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
1200 Walnut Avenue | | |
| 5. SEX
Female | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widowed | 8. DATE OF BIRTH
8-6-1891 | 9. AGE (In years last birthday)
75 | If Under 1 Yr. Months: Days: Hours: Min.
If Under 24 Hrs. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | | 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. |
| 13. FATHER'S NAME
Howard E. Shoop | | | 14. MOTHER'S MAIDEN NAME
Amanda | | |
| 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS
Harold E. Stotler, 1200 Walnut Avenue 21229 | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)
CAUSE OF DEATH
(A) <u>Coronary Occlusion</u>
DUE TO
(B) <u>Hypertension</u>
DUE TO
(C) _____
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Nov. 8</u> 1965 to <u>May 2</u> 1967 , that (I) (we) last saw the deceased alive on <u>Apr. 14</u> 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>George E. Shannon</u> | | | | 23B. DATE SIGNED
May 2, 1967 | |
| 23C. PHYSICIAN'S NAME (Type)
Dr. George Shannon | | | | 23D. ADDRESS
412 Medical Arts Bldg. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
5-5-1967 | | 24C. NAME OF CEMETERY or CREMATORY
Mt. Zion Cemetery | |
| 24D. LOCATION (City, town, or county) (State)
Boonsboro, Maryland | | 25A. DATE REC'D BY HEALTH DEPT.
MAY 3 1967 | | | |
| 25B. NAME OF REGISTRAR
<u>Robert E. Taylor</u> | | 25C. FUNERAL DIRECTOR ADDRESS
Howard H. Hubbard, 4107 Wilkens Ave. 21229 | | | |



R-340

BALTIMORE CITY HEALTH DEPARTMENT

| BIRTH NO. 67-3186 | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 4340 | |
|---|------------------|---|-------------------------------|
| M.E. CASE NO. | | | |
| 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR PRONOUNCED DEAD | |
| RONALD E.J. RATTELL, Jr. | | 5-2-67 647 AM M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION
ST. AGNES HOSPITAL - DOA | | A. STATE
Maryland | |
| | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore | |
| | | D. STREET ADDRESS (If rural, give location)
3612 Greenvale Road | |
| 5. SEX
Male | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)
Single | 8. DATE OF BIRTH
2-15-1967 |
| 9. AGE (In years last birthday)
XXXXXXX | | 10. If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.
2 17 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Child | | 10B. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country)
Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Ronald E. Rattell | | 14. MOTHER'S MAIDEN NAME
Mary J. Sindelar | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
Mr. R.E. Rattell, 3612 Greenvale Rd., 21229 | | ADDRESS | |
| 18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
INTERSTITIAL PNEUMONITIS - (SDII)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Purulent otitis media, right | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No)
Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
Yes | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | |
| 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>
CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ACTUAL SIGNATURE <i>Werner U. Spitz</i> M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
EXAMINER'S NAME (Type) WERNER U. SPITZ, M.D. ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>
DATE SIGNED 5-2-67 | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 23B. DATE
5-3-1967 | |
| 23C. NAME OF CEMETERY OR CREMATORY
New Cathedral Cemetery | | 23D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | |
| 24A. DATE REC'D BY HEALTH DEPT.
MAY 3 1967 | | 24B. NAME OF REGISTRAR
Robert E. Farley, M.D. | |
| 24C. FUNERAL DIRECTOR
Howard H. Hubbard, 4107 Wilkens Ave. 21229 | | ADDRESS | |

19670004340

Werner J. K.

BIRTH NO. **67 4341** MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. **67 4341**

M.E. CASE NO.

| | | | | | | | |
|--|-------------------------|--|--|--|--|--|---|
| 1. NAME OF DECEASED
(Type or Print)
HAROLD W. Davis Jr. | | | | 2. DATE AND HOUR PRONOUNCED DEAD
4-30-67 12:45 PM. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
1925 E. Pratt Street - Amb. Crew #10 | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
1925 E. Pratt Street 21231 | | | |
| 5. SEX
Male | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)
Single | 8. DATE OF BIRTH
7-23-1940 | 9. AGE (In years last birthday)
26 | If Under 1 Yr. If Under 24 Hrs.
Months, Days, Hours, Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Auto Parts Man | | | 10B. KIND OF BUSINESS OR INDUSTRY
Mechanic | | 11. BIRTHPLACE (State or foreign country)
Chester Penna. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. |
| 13. FATHER'S NAME
Harold W. Davis Sr. | | | | 14. MOTHER'S MAIDEN NAME
Elizabeth M. Flakeley | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
Yes | | 16. SOCIAL SECURITY NO.
213-38-6155 | | 17. INFORMANT ADDRESS
Mrs Elizabeth Cox 2845 Cub Hill Road 3 | | | |
| 18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Craniocerebral injury
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
Yes | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
Home | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
1925 E. Pratt Street | | | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour)
4 30 '67 12:15 PM | | 21E. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR?
Presumably fell | | | |
| 22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>
CHIEF MEDICAL EXAMINER <input type="checkbox"/>
M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>
ACTUAL SIGNATURE Werner U. Spitz NAME (Type) WERNER U. SPITZ, M.D. DATE SIGNED 5-1-67 | | | | | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 23B. DATE
5-3-1967 | | 23C. NAME OF CEMETERY or CREMATORY
Rock Run Church Cemetery | | 23D. LOCATION (City, town, or county) (State) | |
| 24A. DATE REC'D BY HEALTH DEPT.
MAY 3 1967 | | 24B. NAME OF REGISTRAR
Robert E. Fink | | 24C. FUNERAL DIRECTOR
Lossary Funeral Home 7401 Belair Road | | ADDRESS (36) | |

6-1-5

WALTER E. FORD

VALLEY CENTER

2-1-5

Walter E. Ford

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 4342 | |
|--|-------------------------|---|-----------------------------------|---|--|
| BIRTH NO. 66-16075 67 4342 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) DONALD ANTHONY DUKE | | 2. DATE AND HOUR OF DEATH
4-29-67 12.50 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE | |
| FULL NAME OF HOSPITAL OR INSTITUTION
33 THE JOHNS HOPKINS HOSPITAL | | D. STREET ADDRESS (If rural, give location)
1101 MERIDENE DRIVE 21212 | | 27-38 | |
| 5. SEX
MALE | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED
NEVER MARRIED | 8. DATE OF BIRTH
8-5-66 | 9. AGE (In years last birthday)
8 | If Under 1 Yr. Months: 24 If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
None | | 10B. KIND OF BUSINESS OR INDUSTRY
None | | 11. BIRTHPLACE (State or foreign country)
Baltimore, Maryland | |
| 13. FATHER'S NAME
DONALD L. DUKE | | 14. MOTHER'S MAIDEN NAME
FRANCES FEEHLEY | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT ADDRESS
Mr Donald L. Duke 1101 Meridene Drive | |
| 18. 299X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Antecedent Causes
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) Due to Congenital Agammaglobulinemia
(B) Due to Hypersplenism & Thrombocytopenia
(C) Pneumonia | | INTERVAL BETWEEN ONSET AND DEATH | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | On toxic drugs for infection | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 3/19 19 67 to 4/29 19 67 , that (I) (we) last saw the deceased alive on 4/29 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Richard D. Bland | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
4/29/67 | |
| 23C. PHYSICIAN'S NAME (Type)
RICHARD D. BLAND | | 23D. ADDRESS
M.D. THE JOHNS HOPKINS HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
5-2-1967 | | 24C. NAME OF CEMETERY OR CREMATORY
Lakeview Mem. Cemetery | |
| 24D. LOCATION (City, town, or county) (State)
Baltimore Md | | 25A. DATE RECEIVED BY HEALTH DEPT.
MAY 3 1967 | | | |
| 25B. NAME OF REGISTRAR
Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR
Loughlin Funeral Home 7401 Belair Road | | ADDRESS 34 | |

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 100. *Thymus*

On toxic drugs for infants.

9/5/9

$\frac{1}{2}$

62

PC/4

5/25/12

Richard D. Webb

Released by medical examiner on approval

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | | | | |
|--|--|--------------|--|---|---|------------------------------|--|---------------------------------------|--|--|--|-----------------------------|--|--|
| BIRTH NO. 67 4343 | | | | | CERTIFICATE OF DEATH | | | | | Registered No. 67 4343 | | | | |
| M.E. CASE NO. | | | | | 1. NAME OF DECEASED
(Type or Print) CHARLES TIRSCHIAN | | | | | 2. DATE AND HOUR OF DEATH
4/27/1967 1:00 P.M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md B. COUNTY Balt Co. | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore 53-00 | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
MARYLAND GEN. HOSP.
48 | | | | | D. STREET ADDRESS (If rural, give location)
5720 Hamilton Ave | | | | | | | | | |
| 5. SEX
M | | 6. RACE
W | | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Wid | | 8. DATE OF BIRTH
12-08-82 | | 9. AGE (In years last birthday)
84 | | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired | | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | | | 11. BIRTHPLACE (State or foreign country)
Balt. Md | | | | |
| 12. CITIZEN OF WHAT COUNTRY?
US | | | | | 13. FATHER'S NAME
Unknown | | | | | 14. MOTHER'S MAIDEN NAME
Unknown | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
UNK | | | | | 16. SOCIAL SECURITY NO.
213-36-8016 | | | | | 17. INFORMANT
Daughter | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of death, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
Pneumonia | | | | | CAUSE OF DEATH | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | (A) DUE TO | | | | | (B) DUE TO | | | | |
| | | | | | (C) DUE TO | | | | | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | Pathologic fracture of hip due to metastatic carcinoma of the lung | | | | | | | | | |
| 19A. DATE OF OPERATION
4/26/67 | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
Fr L Hip | | | | | 20A. AUTOPSY? (Yes or No)
Yes | | | | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
(Lung) | | | | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
Yes - Related to Accident | | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
Home | | | | |
| 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)
Baltimore 53-00 | | | | | 21D. TIME OF INJURY (APPROX.)
4/17/67 | | | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | | | |
| 21F. HOW DID INJURY OCCUR?
Fall in Bathroom | | | | | 22. I certify that (I) (this hospital) attended the deceased from 4/13 1967 to 4/27 1967, that (I) (we) last saw the deceased alive on 4/27 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
Edw A Person | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | | 23B. DATE SIGNED
4/27/67 | | | | |
| 23C. PHYSICIAN'S NAME (Type)
Edw A Person | | | | | 23D. ADDRESS
M.D. 170 Gen. Hosp. | | | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | | | | 24B. DATE
5/1/67 | | | | | 24C. NAME OF CEMETERY or CREMATORY
Schwartz | | | | |
| 24D. LOCATION (City, town, or county) (State)
Baltimore Md | | | | | 25A. DATE REC'D BY HEALTH DEPT.
MAY 3 1967 | | | | | 25B. NAME OF REGISTRAR
Robert E. Taylor | | | | |
| 25C. FUNERAL DIRECTOR
Connelly JH | | | | | ADDRESS
300 Moore | | | | | | | | | |

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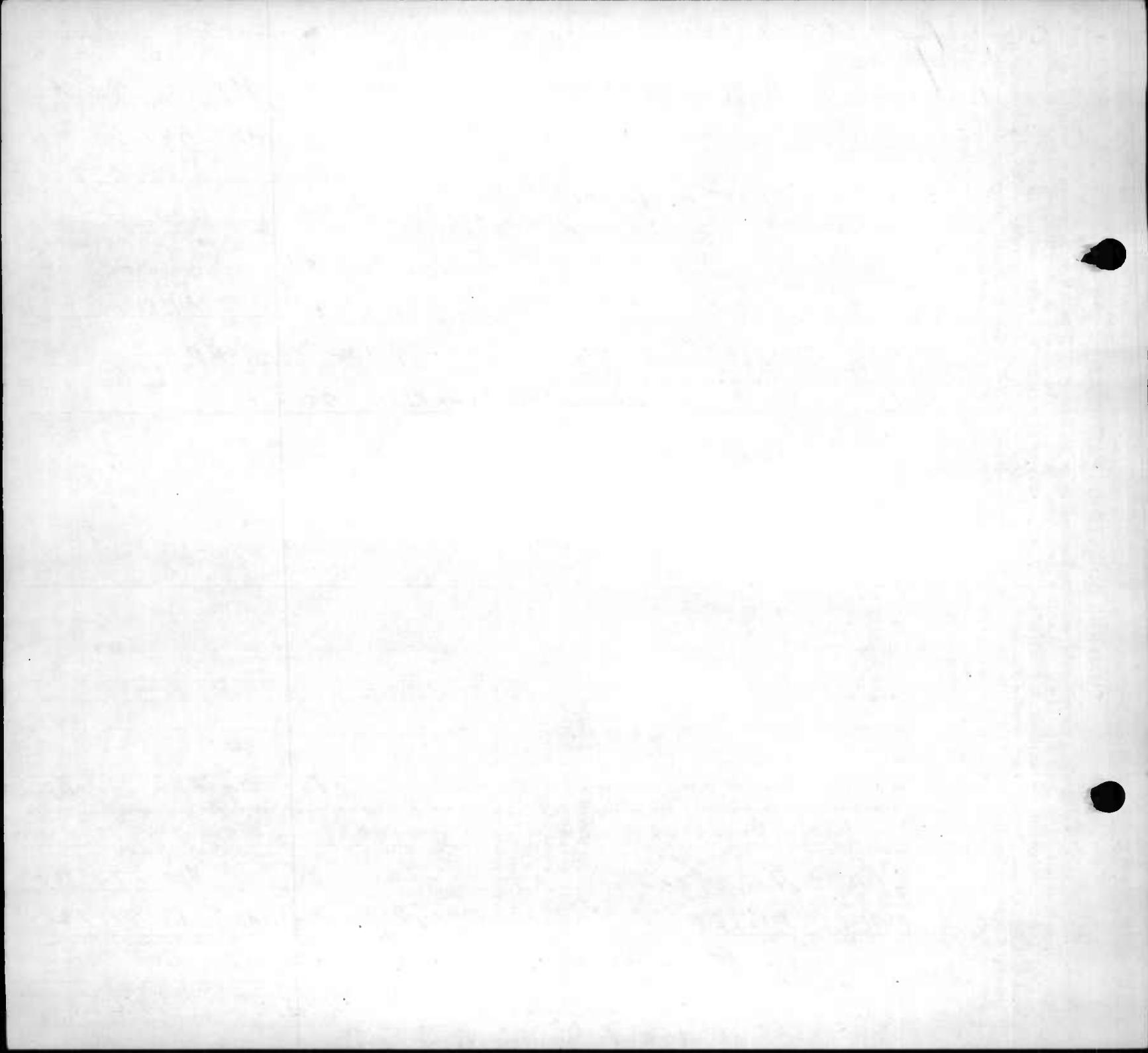


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | Registered No. 67 4344 | |
|---|-------------------------|--|---|--|--|--|--|--|--|--|--|
| BIRTH NO. 67 4344 | | | | | | | | | | 67 4344 | |
| M.E. CASE NO. | | | | | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) LEIBY, HAROLD KENNARD | | | | | 2. DATE AND HOUR OF DEATH
Apr. 29. 1967 9⁰⁰ A. M. | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
FRANKLIN SQUARE HOSPITAL | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE (BALTIMORE) MARYLAND
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE 27-48
D. STREET ADDRESS (If rural, give location)
1018 TUNBRIDGE ROAD. 12 | | | | | | |
| 5. SEX
MALE | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
MARRIED | 8. DATE OF BIRTH
5-1-05 | 9. AGE (In years last birthday)
61 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
CLERK | | 11. BIRTHPLACE (State or foreign country)
PENNSYLVANIA | | 12. CITIZEN OF WHAT COUNTRY?
AMERICA | | |
| 13. FATHER'S NAME
LEIBY, CHARLES EDWARD | | | | | 14. MOTHER'S MAIDEN NAME
GERTRUDE KENNARD | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
UNK | | | | | 16. SOCIAL SECURITY NO.
216-10-2950 | | 17. INFORMANT ADDRESS
FRANKLIN SQUARE | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
4-20-17-163X | | | | | CAUSE OF DEATH
(A) Voluntine coronary art. Dis. old.
(B) with Ca. of the Lung 4 mos? old
(C) with Abdominal Aneurysm? | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | |
| 19A. DATE OF OPERATION
0 | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nately medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 4-25 19 67 to 4-29 19 67 , that (I) (we) last saw the deceased alive on 4-29 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE
Chall Hi Lee | | | | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
Apr. 29. 1967 | |
| 23C. PHYSICIAN'S NAME (Type)
CHALL HI LEE | | | | | | | | 23D. ADDRESS
M.D. FRANKLIN SQUARE HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Removal | | | 24B. DATE
4/29/67 | | 24C. NAME OF CEMETERY or CREMATORY
Hoffman Memorial Park | | | 24D. LOCATION (City, town, or county) (State)
New Castle, Craig Co. Va. | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 3 1967 | | | 25B. NAME OF REGISTRAR
Robert E. Farley | | | 25C. FUNERAL DIRECTOR
James E. Taitel | | | ADDRESS
New Castle, Va. | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|------------------|--|---|---|--|---|--|----------------------------|--|
| BIRTH NO. 67 4345 | | | | | REGISTERED No. 67 4345 | | | | |
| M.E. CASE NO. | | | | | CERTIFICATE OF DEATH | | | | |
| 1. NAME OF DECEASED
(Type or Print) SCHREIBER FERDINAND | | | | | 2. DATE AND HOUR OF DEATH
MAY 2 1967 10:00 A.M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
ST AGNES HOSPITAL
CATON AND WILKENS AVE. BALTO MD | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD B. COUNTY Anne Arundel
C. CITY OR TOWN (If outside city limits, write RURAL and give township) N. LINTHICUM
D. STREET ADDRESS (If rural, give location) 8 SOUTH OLD ANNAPOLIS RD. | | | | |
| 5. SEX
MALE | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
MARRIED | 8. DATE OF BIRTH
1-29-07 | 9. AGE (In years last birthday)
60 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Elec. Welder Ret. | | | 10B. KIND OF BUSINESS OR INDUSTRY
Beth Steel | | 11. BIRTHPLACE (State or foreign country)
MD | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | |
| 13. FATHER'S NAME
JOHN DAVID Schreiber | | | | | 14. MOTHER'S MAIDEN NAME
MARGARET A. HARTHAUSEN | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | 16. SOCIAL SECURITY NO.
215 01 3036 | | 17. INFORMANT ADDRESS
ST AGNES HOSPITAL CATON & WILKENS AVE. | | | | |
| 18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | INTERVAL BETWEEN ONSET AND DEATH
APPROX 3 YRS. (SINCE 1965) | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION
5/1/67 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
CARCINOMA OF THE LUNG & AIRWAY OBST-NO | | | 20A. AUTOPSY? (Yes or No)
-RUCTION. | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from APRIL 25 1967 to MAY 2 1967, that (I) (we) last saw the deceased alive on MAY 2 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
Thamnoon Penroach M.D. | | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | 23B. DATE SIGNED
5-2-67 | |
| 23C. PHYSICIAN'S NAME (Type)
THAMNOON PENROACH M.D. | | | | | 23D. ADDRESS
CATON & WILKENS AVE. BALTIMORE MD | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
May 5, 67 | | 24C. NAME OF CEMETERY or CREMATORY
Glen Haven Mem'l Park | | | 24D. LOCATION (City, town, or county) (State)
Glen Burnie, Md. | | |
| 25A. DATE RECEIVED BY HEALTH DEPT.
MAY 3 1967 | | | 25B. NAME OF REGISTRAR
Robert E. Taylor | | | 25C. FUNERAL DIRECTOR ADDRESS
R.V. SINGLETON, GLEN BURNIE, MD. | | | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>67 4346</u> | |
|---|-------------------------|--|--|---|--|
| BIRTH NO. <u>67 4346</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 2. DATE AND HOUR OF DEATH
<u>April 26, 1967</u> <u>4:30pm.</u> | | | |
| 1. NAME OF DECEASED
(Type or Print) <u>Camille Marcel Siquot.</u> | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>00 4813 GwynnOak Ave., Baltimore, Md.</u> | | A. STATE <u>Md.</u>
B. COUNTY | | | |
| | | C. CITY OR TOWN (If outside city limits, write <u>RURAL</u> and give township)
<u>Baltimore 7, Md.</u> | | | |
| | | D. STREET ADDRESS (If rural, give location)
<u>4813 GwynnOak Ave.</u> | | | |
| 5. SEX
<u>Male</u> | 6. RACE
<u>White</u> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<u>widowed</u> | 8. DATE OF BIRTH
<u>Aug. 19, 1874</u> | 9. AGE (In years last birthday)
<u>92 yrs.</u> | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Retired</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>Taylor & Fisher</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Paris, France</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | 13. FATHER'S NAME
<u>unknown</u> | | 14. MOTHER'S MAIDEN NAME
<u>unknown</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>218-22-9361A</u> | | 17. INFORMANT
<u>Baltimore 7, Md.</u>
<u>Miss Edythe Siquot, 4813 Gwyn Oak Ave.</u> | |
| 18. <u>350X I</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION first. | | CAUSE OF DEATH
(A) <u>Parkinson's Disease</u>
DUE TO
(B) <u>Generalized Arteriosclerosis</u>
DUE TO
(C) <u>Age</u> | | INTERVAL BETWEEN ONSET AND DEATH | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
<u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<u>No</u> | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>April 19 1967</u> to <u>April 27 1967</u> , that (I) (we) lost saw the deceased alive on <u>April 26 1967</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. <u>April 27</u> | | | | | |
| 23A. SIGNATURE
<u>Lee J. Volenick</u> | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
<u>4/27/67</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>Lee J. Volenick</u> | | 23D. ADDRESS
<u>4710 LIBERTY HTS AVE</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>April 29, 1967</u> | | 24C. NAME OF CEMETERY or CREMATORY
<u>Druid Ridge Cemetery</u> | |
| 24D. LOCATION (City, town, or county) (State)
<u>Pikesville 8, Maryland</u> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>MAY 3 1967</u> | | 25B. NAME OF REGISTRAR
<u>Dr. J. E. Edwards</u> | | 25C. FUNERAL DIRECTOR
<u>Frank H. Newell</u> | |
| 25D. ADDRESS
<u>Pikesville 8, Md.</u> | | | | | |

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BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 67 4347

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

67 4347

M.E. CASE NO.

| | | | | | | | |
|---|-------------------------|--|---------------------------------------|---|---|--|--|
| 1. NAME OF DECEASED
(Type or Print) MARY NADINE ALBERT | | | | 2. DATE AND HOUR PRONOUNCED DEAD
5-2-67 11:30 AM | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
3420 GARRISON BOULEVARD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY 15-10 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
3420 GARRISON BOULEVARD | | | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore | | | |
| D. STREET ADDRESS (If rural, give location)
3420 Garrison Boulevard | | | | | | | |
| 5. SEX
Female | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widowed | 8. DATE OF BIRTH
12-10-1883 | 9. AGE (In years last birthday)
83 | If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Clerk | | 10B. KIND OF BUSINESS OR INDUSTRY
U.S.F.M. | | 11. BIRTHPLACE (State or foreign country)
Baltimore | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Austin Winters | | | | 14. MOTHER'S MAIDEN NAME
MAMIE KENNY | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | | 16. SOCIAL SECURITY NO.
215-22-8063 | | 17. INFORMANT ADDRESS
NADINE Lotz - Bay 334 - Ocean City, Md | |
| 18. CAUSE OF DEATH
I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Arteriosclerotic cardiovascular disease
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>
CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ACTUAL SIGNATURE Werner U. Spitz M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
EXAMINER'S NAME (Type) WERNER U. SPITZ, M.D. ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>
DATE SIGNED 5-2-67 | | | | | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 23B. DATE
5-4-67 | | 23C. NAME OF CEMETERY or CREMATORY
New Cathedral Cem - | | 23D. LOCATION (City, town, or county) (State)
BALTIMORE, Md | |
| 24A. DATE REC'D BY HEALTH DEPT.
MAY 3 1967 | | 24B. NAME OF REGISTRAR
R. E. F. Jones | | 24C. FUNERAL DIRECTOR ADDRESS
Elkworth Armacost - 4601 Liberty Heights | | | |



James R. Smith

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. **67 4348**BIRTH NO. **67 4348**

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

(EUGENIA) EUGENIA M. MARTIN

2. DATE AND HOUR PRONOUNCED DEAD

April 28, 1967 12:30 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)**00 829 N. Eutaw Street**4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE**Maryland**

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore # 21201. 11-B

D. STREET ADDRESS (If rural, give location)

829 N. Eutaw Street

5. SEX

Female

6. RACE

White7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)**Divorced**

8. DATE OF BIRTH

Jan. 14, 19149. AGE (In years
last birthday)**53**If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)**Waitress**

10B. KIND OF BUSINESS OR INDUSTRY

Restaurant

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.12. CITIZEN OF
WHAT COUNTRY?**U.S.A.**

13. FATHER'S NAME

Konstanty Gizinski

14. MOTHER'S MAIDEN NAME

Constance Demboski15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)**No**16. SOCIAL
SECURITY NO.**213-01-3117**

17. INFORMANT

ADDRESS

Marian J. Smyth 8617 Fowler Ave. 34, Md. Balto.,

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) _____
DUE TO**Cirrhosis of liver**

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) _____
DUE TO

(C) _____

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRI-
BUTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)**Charles S. Springate, M.D.**CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

April 28, 196723A. BURIAL CREMATION,
REMOVAL (Specify)**Burial**

23B. DATE

5-2-67

23C. NAME of CEMETERY or CREMATORY

St. Alphonsus Cemetery

23D. LOCATION

(City, town, or county)

(State)

Woodstock, Md.

24A. DATE REC'D BY HEALTH DEPT.

MAY 3 1967

24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

Charles S. SpringateADDRESS
**901 S. Conkling St.
Balto., 21224, Md.**

RECEIVED FOR THE

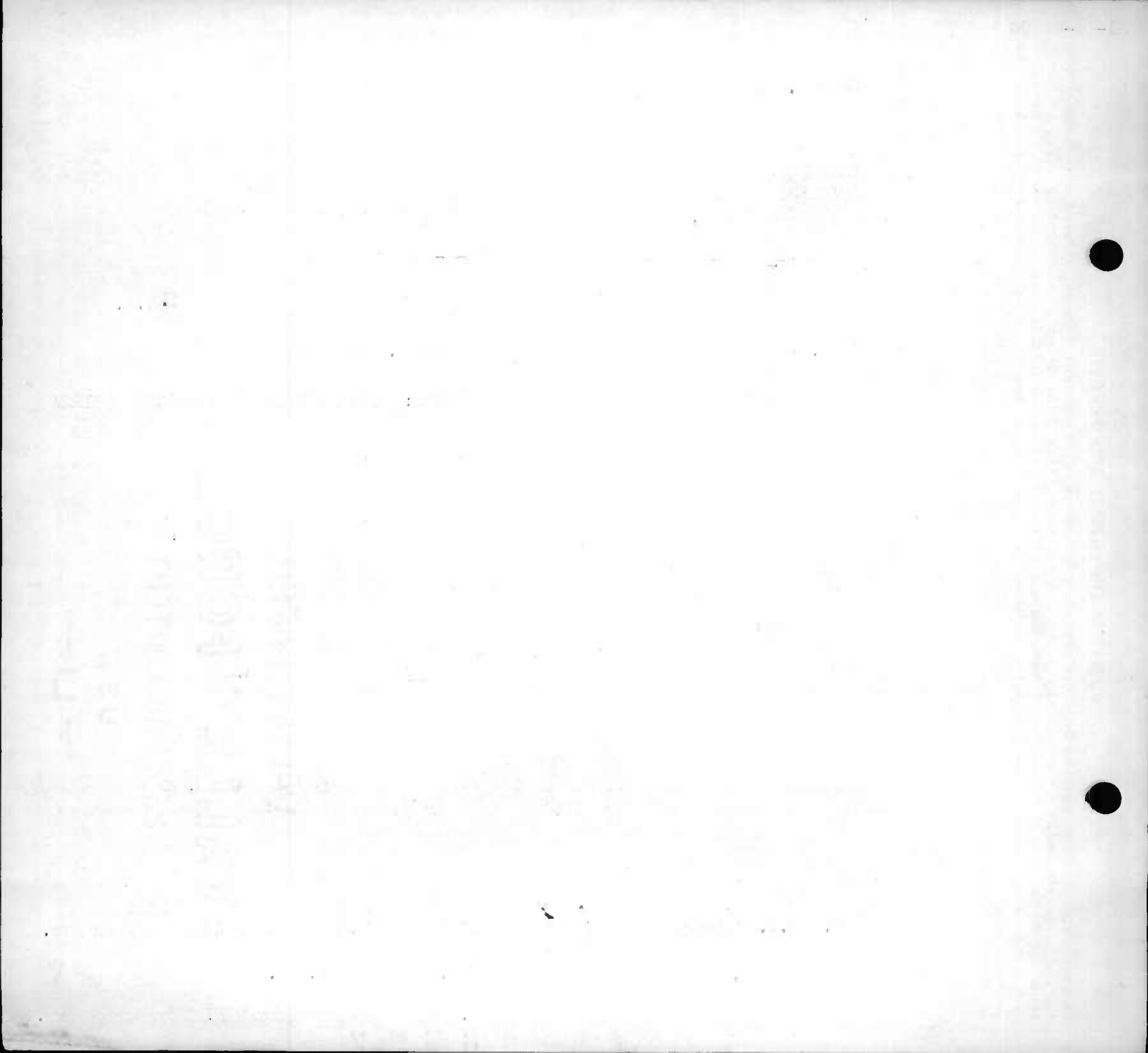
PAPER

Handwritten signature

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

FUNERAL DIRECTOR: IMPORTANT

| | | | | | |
|---|------------------|---|--|--|---|
| BIRTH NO. 24067 4349 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 4349 | |
| M.E. CASE NO. | | | 2. DATE AND HOUR OF DEATH | | |
| 1. NAME OF DECEASED
(Type or Print) Gary F. Maxwell | | | 4-30-67 8:20 P.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
BALTIMORE CITY HOSPITALS
4940 EASTERN AVENUE
BALTIMORE 21224, MARYLAND | | | A. STATE MARYLAND
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE
D. STREET ADDRESS (If rural, give location)
2028 62nd STREET #21206 | | |
| 5. SEX
Male | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Single | 8. DATE OF BIRTH
10-9-41 | 9. AGE (In years lost birthday)
25 | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
None | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | |
| 13. FATHER'S NAME
Francis G. Maxwell | | | 14. MOTHER'S MAIDEN NAME
Laris V. Cox | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
RECORDS: BCH 4940 EASTERN AVENUE #21224 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH
(A) DUE TO
(B) DUE TO
(C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH
12 yrs
14 yrs |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 4-14-1967 to 4-30-1967, that (I) (we) last saw the deceased alive on 4-30-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Dr. A.P. Weinfeld | | | 23B. DATE SIGNED
4-30-67 | | 23C. PHYSICIAN'S NAME (Type)
Dr. A.P. Weinfeld |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | | 24B. DATE
May 2, 1967 | | 24C. NAME OF CEMETERY or CREMATORY
Gardens Of Faith Cem. |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 3 1967 | | | 25B. NAME OF REGISTRAR
G. Truman | | 25C. FUNERAL DIRECTOR
Schwab 3512 Frederick Ave. |



R-300

| BALTIMORE CITY HEALTH DEPARTMENT | | | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | |
|---|---------|--|---|---|---|--|--|
| BIRTH NO. <u>67 4350</u> | | | | Registered No. <u>67 4350</u> | | | |
| M.E. CASE NO. | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) | | | | 2. DATE AND HOUR PRONOUNCED DEAD | | | |
| PHILIP W. RUEDA | | | | 4-30-67 4:10 PM M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | A. STATE B. COUNTY | | | |
| ST. AGNES HOSPITAL - DOA | | | | Maryland Baltimore | | | |
| C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) | | | | D. STREET ADDRESS (If rural, give location) | | | |
| Joppatown | | | | 1062 Plaza Circle | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | | |
| Male | White | Never Married | Sept. 23, 1966 | | 07 | 7 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | | |
| None | | | Bainbridge, Md | | | | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | | | |
| Paul Rueda | | | Elizabeth Pikey | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | |
| No | | | None | | Mr. Paul Rueda, 1062 Plaza Ct. Joppatown, Md | | |
| 18. CAUSE OF DEATH | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | (A) Asphyxiated by plastic mattress cover | | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | DUE TO | | | |
| ANTECEDENT CAUSES | | | | (B) DUE TO | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | | | (C) DUE TO | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 2 | | | | Yes | | Yes | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | Crib | | 241 Montgomery Road | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| (Month) (Day) (Year) 4 30 '67 PM | | WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | Was in crib - Pulled plastic cover over face | | | |
| 22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE | | | | CHIEF MEDICAL EXAMINER | | | |
| EXAMINER'S NAME (Type) WERNER U. SPITZ, M.D. | | | | M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| | | | | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) | | 23B. DATE | | 23C. NAME OF CEMETERY or CREMATORY | | 23D. LOCATION (City, town, or county) (State) | |
| Burial | | 5-3-1967 | | St. Johns | | Ellicott City, Md | |
| 24A. DATE REC'D BY HEALTH DEPT. | | 24B. NAME OF REGISTRAR | | 24C. FUNERAL DIRECTOR | | ADDRESS | |
| MAY 3 1967 | | Robert E. Feltner | | F.C. Higinbotham | | Ellicott City, Md | |

034

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

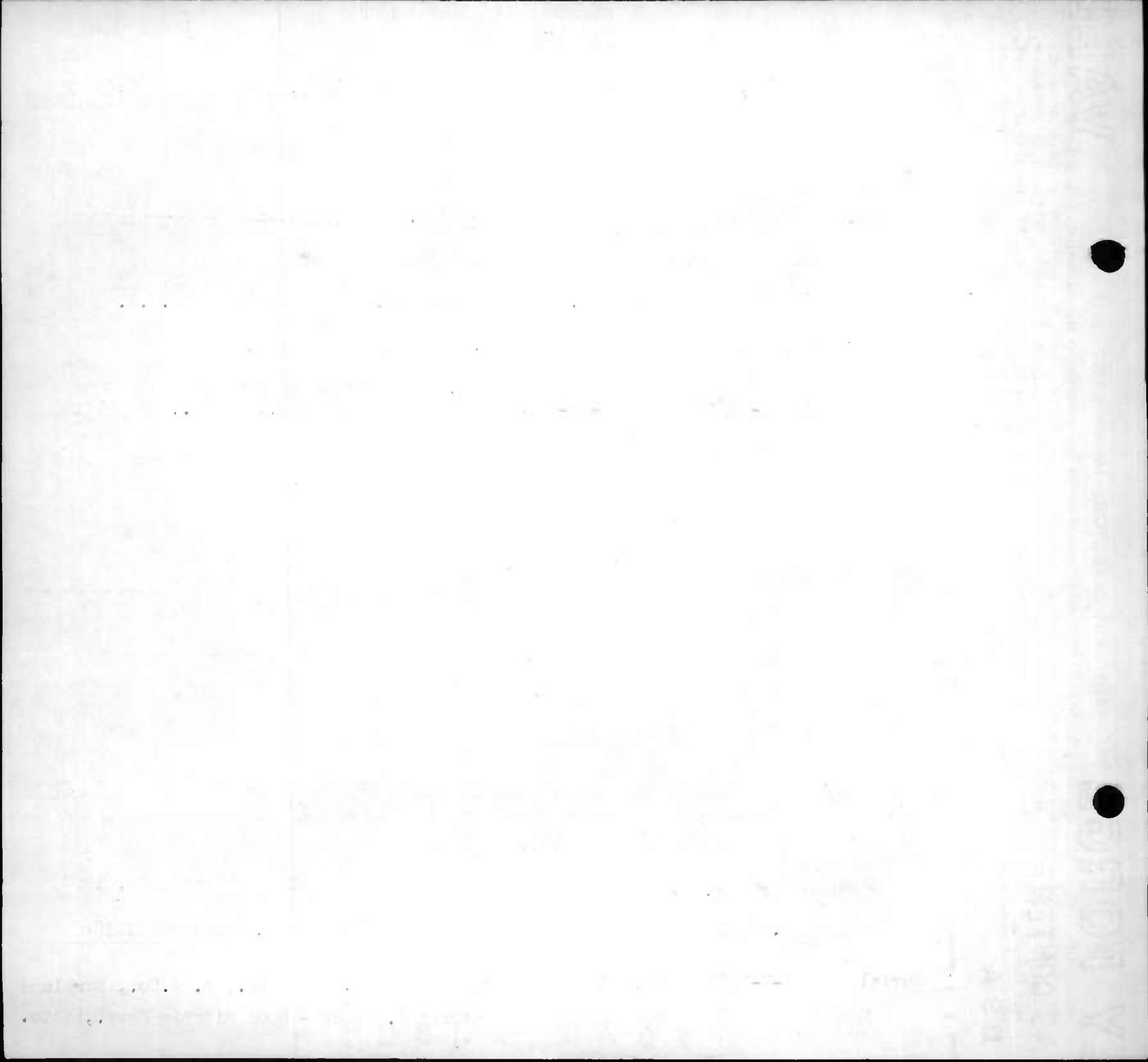
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 4351 | |
|--|-------------------------|---|---|--|---|
| BIRTH NO. 67 4351 | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED
(Type or Print) GROSSKETTLER, Paul Andrew | | | | 2. DATE AND HOUR OF DEATH
April 27, 1967 2:35 P M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Veterans Administration Hospital
3900 Loch Raven Boulevard
Baltimore, Maryland 21218 | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY

C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
3827 W. Patapsco Avenue | |
| 5. SEX
Male | 6. RACE
White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
Widowed | 8. DATE OF BIRTH
1/29/20 | 9. AGE (In years last birthday)
47 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Salesman | | 10B. KIND OF BUSINESS OR INDUSTRY
Ice Cream Co. | | 11. BIRTHPLACE (State or foreign country)
Shenandoah, Pennsylvania | |
| 13. FATHER'S NAME
John M Grosskettler | | | 14. MOTHER'S MAIDEN NAME
E. Catherine Schmidt | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
Yes 2/12/42 - 7/23/45 | | 16. SOCIAL SECURITY NO.
217-26-8266 | | 17. INFORMANT ADDRESS
Veterans Administration Hospital
3900 Loch Raven Blvd., Balto., Md 21218 | |
| 18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Bronchogenic Carcinoma
INTERVAL BETWEEN ONSET AND DEATH
1 year

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initially medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from April 26th 1967 to April 27th 1967 , that (1) (we) lost saw the deceased alive on April 27th 1967 and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (not) view the body after death. | | | | | |
| 23A. SIGNATURE
Domingo A. Garcia | | | | 23B. DATE SIGNED
April 28, 1967 | |
| 23C. PHYSICIAN'S NAME (Type)
DOMINGO A. GARCIA | | | | 23D. ADDRESS
M.D. VA HOSPITAL Baltimore, Maryland 21218 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
5-1-1967 | | 24C. NAME OF CEMETERY OR CREMATORY
Holy Cross Cemetery | |
| 24D. LOCATION (City, town, or county) (State)
Ritchie Hwy., A. A. Co., Maryland | | 25A. DATE REC'D BY HEALTH DEPT.
MAY 3 1967 | | | |
| 25B. NAME OF REGISTRAR
Robert E. Farkas | | 25C. FUNERAL DIRECTOR ADDRESS
George J. Gonc - 4001 Ritchie Hwy., Balto. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | BIRTH NO. 67 4352 | | CERTIFICATE OF DEATH | | Registered No. 67 4352 | |
|---|---------------------|---|--|--|--|---|--|------------------------|--|
| 1. NAME OF DECEASED
(Type or Print) WATSON, CHARLOTTE THELMA | | | | 2. DATE AND HOUR OF DEATH
4/29/67 | | 2.5 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE MD B. COUNTY BALT | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
38 UNIV. HOSP. | | (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALT. | | 19-03 | | | |
| | | | | D. STREET ADDRESS (If rural, give location)
333 S. PARRISH ST | | | | | |
| 5. SEX
F | 6. RACE
W | 7. MARRIED NEVER MARRIED
WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH
4/10/21 | 9. AGE (In years last birthday)
46 | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
PA. | | 12. CITIZEN OF WHAT COUNTRY?
USA | | | |
| 13. FATHER'S NAME
FRANCES L. BUSBY | | | | 14. MOTHER'S MAIDEN NAME
LENNORA ? | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
220-07-9984 | | 17. INFORMANT
PT | | ADDRESS | | | |
| 18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Hepatic Coma
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
alcoholic cirrhosis
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | (A) DUE TO | | (B) DUE TO | | (C) DUE TO | |
| | | | | INTERVAL BETWEEN ONSET AND DEATH
4 days | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (1) (this hospital) attended the deceased from 4/16/67 19 to 4/29/67 19, that (2) (we) last saw the deceased alive on 4/29/67 19 and that in (3) (our) opinion death occurred on the date and hour and from the causes stated above (1) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
J. L. Kucase | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
4/29/67 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS
M.D. | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
5/3/67 | | 24C. NAME OF CEMETERY or CREMATORY
Cedar Hill Cemetery | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 3 1967 | | 25B. NAME OF REGISTRAR
Robert E. Farkner | | 25C. FUNERAL DIRECTOR ADDRESS
Walters Funeral Home Pratt & Stricker Sts. | | | | | |

4/8 Knapp

4/21/63

4/21/63

4/21/63

Atlantic Outlines

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FRANCIS GUSBY

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WATKINS WILSON

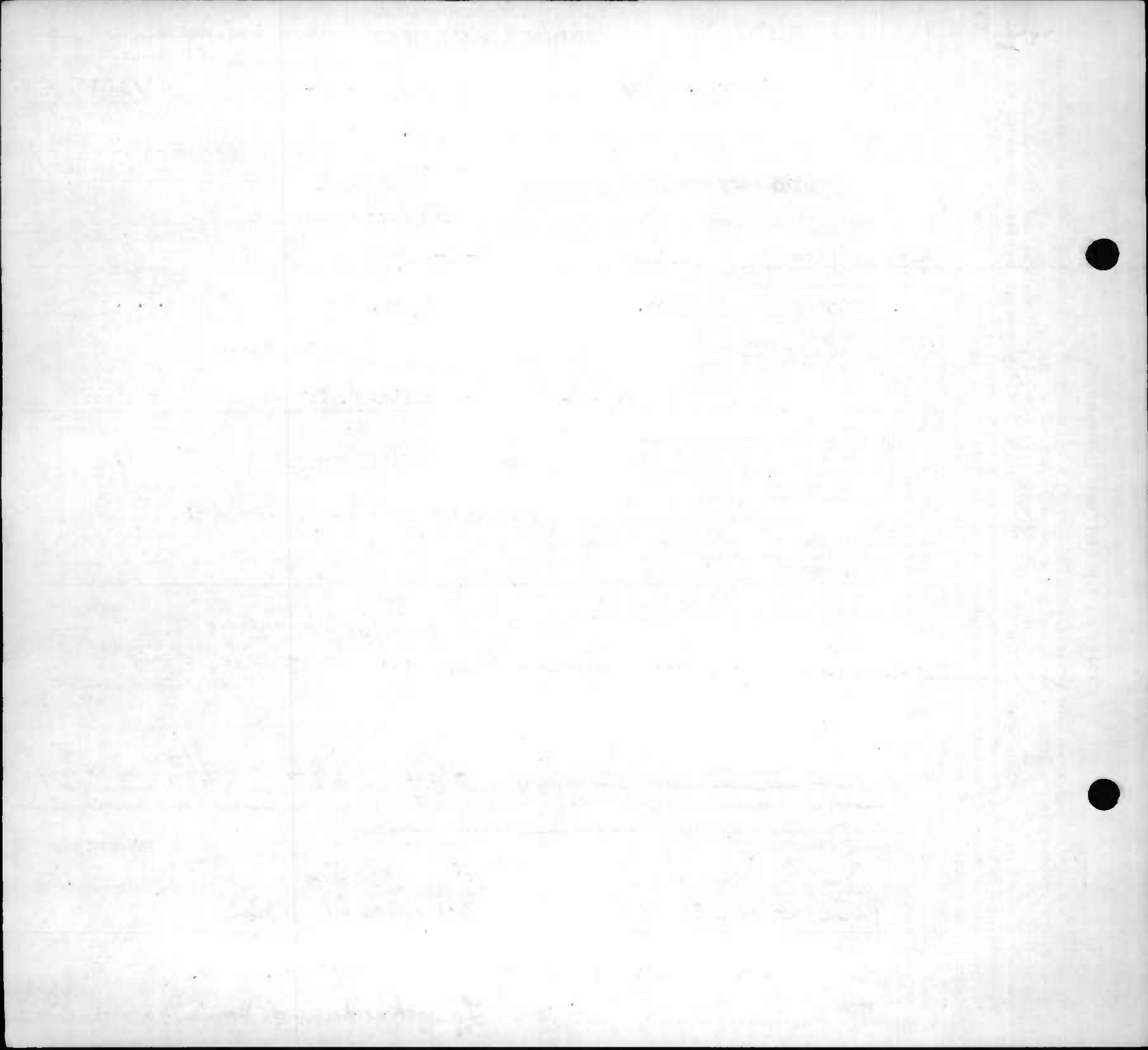
WATKINS

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/65



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|---------------------|--|---|---|--|
| BIRTH NO. 67 4354 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 4354 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) Maria R. Liberto | | | 2. DATE AND HOUR OF DEATH
May 1, 1967 3:30 A.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location):
5009 Frederick Ave.
00 | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 5009 Frederick Ave.
25-31 | | |
| 5. SEX
F | 6. RACE
Cauc. | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widowed | 8. DATE OF BIRTH
Aug. 6, 1884 | 9. AGE (In years last birthday)
82 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country)
Italy | | 12. CITIZEN OF WHAT COUNTRY?
USA |
| 13. FATHER'S NAME
Salvatore Brocato | | | 14. MOTHER'S MAIDEN NAME
Rosa | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
212-48-7988 | 17. INFORMANT
Mrs. Connie Norton
5009 Frederick Rd. - 21229 | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
420.1 I
Hypertensive Cardio-Vascular Disease (Myocardial Infarction) | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (A) DUE TO | | (B) DUE TO |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | (C) DUE TO | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan. 19 50 to 5/1 19 67, that (I) (we) last saw the deceased alive on 4/23 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Joseph R. Liberto | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
5/3/67 |
| 23C. PHYSICIAN'S NAME (Type)
Joseph Liberto | | | 23D. ADDRESS
M.D. 2110 Old Frederick Rd. | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | 24B. DATE
5/4/67 | 24C. NAME OF CEMETERY OR CREMATORY
New Cathedral Cem. | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 3 1967 | | 25B. NAME OF REGISTRAR
Robert E. Farley | | 25C. FUNERAL DIRECTOR
Witzke F. D. - 4101 Edmondson Ave. | |

100 - Frederick Ave.

May 6, 1934

Early

Mass

Mr. Joseph Martin
200 Frederick St. - 21222

212-1103

Salvatore M. Costa

212 Old Frederick St.

Joseph Martin

Salisbury, N.Y.

Mr. Joseph Martin

212

212

212 Old Frederick Ave.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | | | Registered No. 67 4355 | |
|--|----------------------|--|--------------------------------------|--|---|
| BIRTH NO. 67 4355 | | | | | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED
(Type or Print) John W. Davis | | 2. DATE AND HOUR OF DEATH
May 1, 1967 3:50 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
3718 Claremont Street | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
3718 Claremont Street | | | |
| 5. SEX M | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
Married | 8. DATE OF BIRTH
11/8/1899 | 9. AGE (In years last birthday)
67 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
inspector | | 10B. KIND OF BUSINESS OR INDUSTRY
Beth. Steel | | 11. BIRTHPLACE (State or foreign country)
Virginia | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
Charles Wesley | | 14. MOTHER'S MAIDEN NAME
Cora Saunders | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
no | | 16. SOCIAL SECURITY NO.
216-09-5448 A | | 17. INFORMANT
Mrs. Marie Davis | |
| 18. ADDRESS
Same | | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
420.17-260X | | CAUSE OF DEATH
(A) Coronary Thrombosis
DUE TO
(B) Arteriosclerotic C.V. Disease
DUE TO
(C) Chronic myeloiditis | | INTERVAL BETWEEN ONSET AND DEATH
? | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Duodenal Ulcer
Diabetes Mellitus | | ? | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from April 18, 1967 to May 1, 1967 , that (I) (we) last saw the deceased alive on May 1, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Jason H. Gaskel | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
May 2, 1967 | |
| 28C. PHYSICIAN'S NAME (Type)
Jason H. Gaskel | | 23D. ADDRESS
637 S Conkling St. Balt. Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
5/4/67 | | 24C. NAME OF CEMETERY or CREMATORY
Oaklawn Cemetery | |
| 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR
John J. Fadden | | 25C. FUNERAL DIRECTOR
Joseph J. Ziegler | |
| 25D. ADDRESS
263 S. Conkling Street | | | | | |

CERTIFICATE OF DEATH

Registered No.

67 4356

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

MARY A DORSEY

2. DATE AND HOUR OF DEATH

5-1-67

6:30 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

Baltimore City Hospitals

4940 Eastern Ave.

Baltimore, Maryland # 21224

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1233 N. Central Ave.

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED

WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

9/14/08

9. AGE (In years
last birthday)

58

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Domestic

10B. KIND OF BUSINESS OR INDUSTRY

Put Family

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Abe Hill

14. MOTHER'S MAIDEN NAME

Galloway

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

213-22-2242

17. INFORMANT

ADDRESS #21224

BCH: Records 4940 Eastern Ave. Baltimore, Md.

18. 157 X 1

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) DUE TO

Adeno carcinoma stomach

(B) DUE TO

(C) DUE TO

INTERVAL BETWEEN
ONSET AND DEATH

6 months

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 3-22-1967 to 5-1-1967,
that (I) (we) last saw the deceased alive on 5-1-1967 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

H. Tarsy

M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

5/1/67

23C. PHYSICIAN'S
NAME (Type)

Dr. Tarsy

M.D.

23D. ADDRESS

Baltimore City Hospitals
4940 Eastern Ave. Baltimore, Maryland # 2122424A. BURIAL, CREMATION,
REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

Arbutus Park

25A. DATE REC'D BY HEALTH DEPT.

MAY 3 1967

25B. NAME OF REGISTRAR

Robert E. Taylor

25C. FUNERAL DIRECTOR

Thomas P. Hays 638 N. G. corner st

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

107

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A-453

| 67 4357 | | BALTIMORE CITY HEALTH DEPARTMENT | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 4357 | |
|---|--|--|---|---|--|
| BIRTH NO. | | M.E. CASE NO. | | | |
| 1. NAME OF DECEASED
(Type or Print) | | | 2. DATE AND HOUR PRONOUNCED DEAD | | |
| LEONARD (WALTER) ALLENDER | | | 5-1-67 3:50 AM M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
31 BALTIMORE CITY HOSPITAL | | | A. STATE Maryland B. COUNTY Baltimore Co | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Chase 53-00 | | |
| 5. SEX Male | | | 6. RACE Colored | | |
| 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
Single | | | 8. DATE OF BIRTH May 18, 1941 | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Laborer | | | 9. AGE (In years last birthday) 25 | | |
| 10B. KIND OF BUSINESS OR INDUSTRY | | | 11. BIRTHPLACE (State or foreign country)
Chase Md. | | |
| 12. CITIZEN OF WHAT COUNTRY? | | | 13. FATHER'S NAME
Clarence Allender | | |
| 14. MOTHER'S MAIDEN NAME
Sarah Slattery | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | |
| 16. SOCIAL SECURITY NO. | | | 17. INFORMANT
Sarah Allender 1129 N. Carroll St | | |
| 18. CAUSE OF DEATH | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Multiple injuries | | | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 2 | | | | Yes | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
Street | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
Eastern Avenue - 74' East of Bowley's Quarters Road 53-00 | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour)
4 29 '67 10:31 AM | | 21E. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR?
Driver in auto-auto collision | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE
Werner U. Spitz, M.D. | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | |
| EXAMINER'S NAME (Type) | | | DATE SIGNED
5-1-67 | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 23B. DATE
May 3/67 | | 23C. NAME OF CEMETERY OR CREMATORY
Baltimore Natl. Cem. | |
| 23D. LOCATION (City, town, or county) (State)
5501 Fredrick Ave | | 24A. DATE REC'D BY HEALTH DEPT.
MAY 3 1967 | | 24B. NAME OF REGISTRAR
Robert E. Farley, Jr. | |
| 24C. FUNERAL DIRECTOR
J. T. Ellickson | | 24D. ADDRESS
1129 N. Carroll St | | | |

N 869.122 6 1 0 0 0 4 3 6 5

Single

James
Gibson

James
Gibson
Chas. M.
Shaw

James Gibson
Chas. M. Shaw

FUNERAL DIRECTOR: IMPORTANT

49-16-911N

B-165267 4358

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. **67 4358**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| BIRTH NO. | | M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | | | Barnes, Gabriel | | April 30, 1967 11:05 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
BALTIMORE CITY HOSPITALS
4940 EASTERN AVENUE
BALTIMORE, MARYLAND 21224 | | | | A. STATE
B. COUNTY
MARYLAND Baltimore Co. | | | |
| 5. SEX
MALE | | | | 6. RACE
WHITE | | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
WIDOWED | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| Carpenter | | Construction | | KENTUCKY | | U.S.A. | |
| 13. FATHER'S NAME
ELDRIDGE BARNES | | | | 14. MOTHER'S MAIDEN NAME
NANCY | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| No | | 215 14 5906A | | BCH: Records 4940 Eastern Ave. Baltimore, Md. | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)
PULMONARY EMBOLUS | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) DUE TO | | 4 hrs | |
| | | | | (B) DUE TO | | 2 weeks | |
| | | | | (C) DUE TO | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | Yes | | YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 4-28-67 19 to 4-30-67 19, that (I) (we) last saw the deceased alive on 4-30-67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
H. Weinfeld | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
4-30-67 | |
| 23C. PHYSICIAN'S NAME (Type)
DR. A. P. WEINFELD | | | | 23D. ADDRESS
BALTIMORE CITY HOSPITALS
4940 EASTERN AVENUE BALTO. MD. 21224 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
5/3/67 | | 24C. NAME OF CEMETERY or CREMATORY
Holly Hill Memorial Gardens | | 24D. LOCATION (City, town, or county) (State)
Baltimore Co., Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 3 1967 | | 25B. NAME OF REGISTRAR
Robert E. Tanley | | 25C. FUNERAL DIRECTOR
James E. Brudzinski 1407 Eastern Ave. 21 | | | |

10/1/1900

10/1/1900

10/1/1900

10/1/1900

10/1/1900

10/1/1900

10/1/1900

10/1/1900

10/1/1900

10/1/1900

10/1/1900

10/1/1900

10/1/1900

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 67 4359 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | Registered No. 67 4359 | |
|--|---------------------|---|--|---|--|--|--|--|--|
| M.E. CASE NO. | | | | 1. NAME OF DECEASED
(Type or Print) INKELSTEIN BEATRICE | | 2. DATE AND HOUR OF DEATH
1 MAY 1967 4:10 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE MARYLAND
B. COUNTY BALTIMORE | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
48 MARYLAND GENERAL HOSP | | | | D. STREET ADDRESS (If rural, give location)
*717 LAKE DRIVE | | 13-01 | | | |
| 5. SEX
F | 6. RACE
W | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
WIDOWED | | 8. DATE OF BIRTH
? | 9. AGE (In years lost birthday)
± 70 ? | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
NONE | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
ENGLAND | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Jacob HARRIS | | | | 14. MOTHER'S MAIDEN NAME
SARAL ? | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
ELEANOR EDWARDS - 100 E. GLEN SPRING LANE | | ADDRESS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
DEHYDRATION | | | | CAUSE OF DEATH
(A) DUE TO
DEHYDRATION | | INTERVAL BETWEEN ONSET AND DEATH
48 H | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.
ASPIRATION | | | | (B) DUE TO
SECOND DEGREE BURNS | | 48 H + | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | (C) DUE TO | | on ground | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
Home | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
717 Lake Drive | | 13-01 | | | |
| 21D. TIME OF INJURY (APPROX.)
4 28 67 4:10A | | 21E. INJURY OCCURRED
While At <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR?
sat in tub of hot water | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 4-29 19 67 to 5-1 19 67 , that (I) we last saw the deceased alive on 4-29 19 67 and that in (my) last opinion death occurred on the date and hour and from the causes stated above. (I) we (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
Michael B. Flynn | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
5-1-67 | | | |
| 23C. PHYSICIAN'S NAME (Type)
MICHAEL B. FLYNN | | | | M.D. 23D. ADDRESS
Maryland General Hosp | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
5/3/1967 | | 24C. NAME OF CEMETERY or CREMATORY
HEBREW FRIENDSHIP | | 24D. LOCATION (City, town, or county)
BALTO. | | (State)
MD | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 3 1967 | | 25B. NAME OF REGISTRAR
Robert E. Taylor | | 25C. FUNERAL DIRECTOR
SYLVAN S. LEWIS & SON - GARRISON, MD | | ADDRESS | | | |

Marjorie & George
811 Lake Drive
? 4705

Jacob Harris

Ernest
Zarac

John Harris
412 Second Street

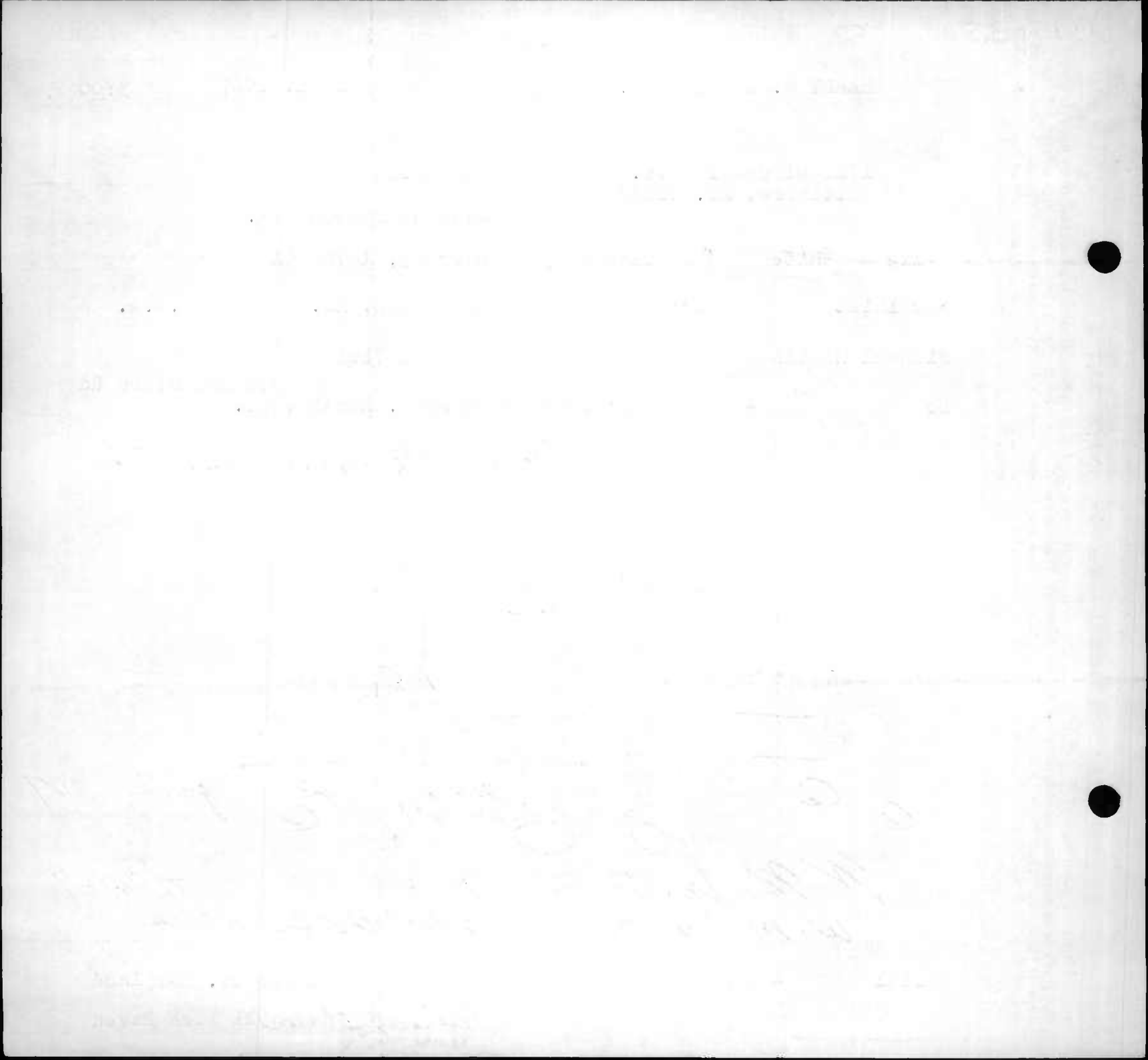
4-24-61
4-2-61

Michael Harris
Michael & George

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

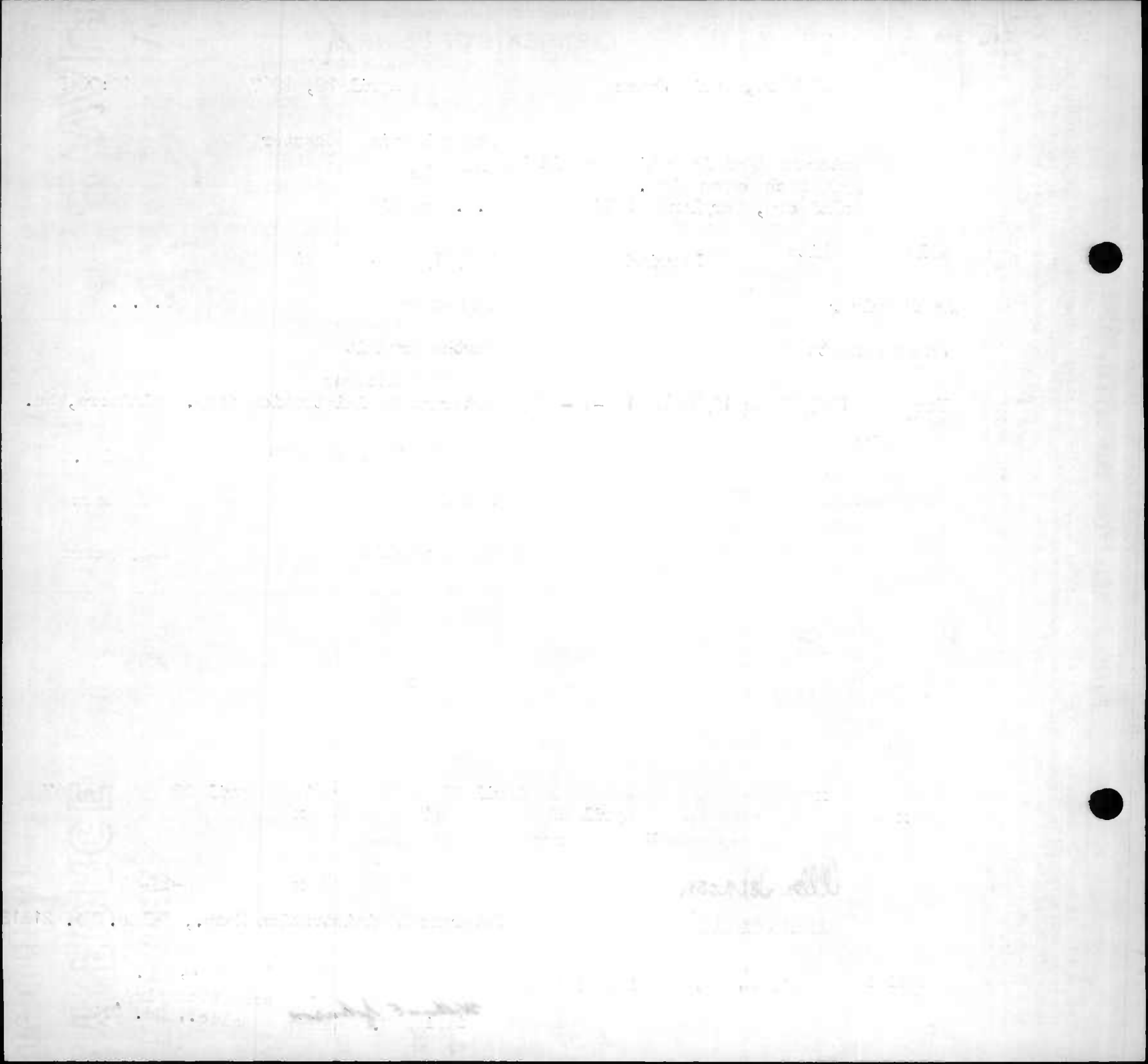
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|---|--|--|--|--|--|--|---|--|
| CERTIFICATE OF DEATH | | | | | Registered No. 67 4360 | | | | |
| BIRTH NO. 67 4360 | | M.E. CASE NO. | | | 2. DATE AND HOUR OF DEATH
April 26, 1967 3:00 P. M. | | | | |
| 1. NAME OF DECEASED
(Type or Print) HARRY M. MARTIN, SR. | | | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
1712 Windemere Ave.
Baltimore, Md. 21218 | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location)
1712 Windemere Ave. | | | | |
| 5. SEX
Male | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married | | 8. DATE OF BIRTH
March 5, 1876 91 | 9. AGE (In years last birthday) | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Machinist | | | | 10B. KIND OF BUSINESS OR INDUSTRY
Automobile | | 11. BIRTHPLACE (State or foreign country)
Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Michael Martin | | | | | 14. MOTHER'S MAIDEN NAME
Pauline Vick | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | | 16. SOCIAL SECURITY NO.
213 09 9689 | | 17. INFORMANT ADDRESS
8310 Dalesford Rd
Harry M. Martin, Jr. | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
Massive Myocardial Infarction | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from MAY 7 1963 to APRIL 2 1967 , that (I) (we) last saw the deceased alive on APRIL 26 1967 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
W. M. Smith | | | | | | | | 23B. DATE SIGNED
4/26/67 | |
| 23C. PHYSICIAN'S NAME (Type)
W. M. Smith | | 23D. ADDRESS
6305 THE ALAMEDA | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
4/28/67 | | 24C. NAME OF CEMETERY OR CREMATORY
Parkwood Cemetery | | 24D. LOCATION (City, town, or county) (State)
Baltimore Co. Maryland | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 3 1967 | | 25B. NAME OF REGISTRAR
Robert E. Taylor | | 25C. FUNERAL DIRECTOR
William E. Johnson | | ADDRESS
8521 Loch Raven | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

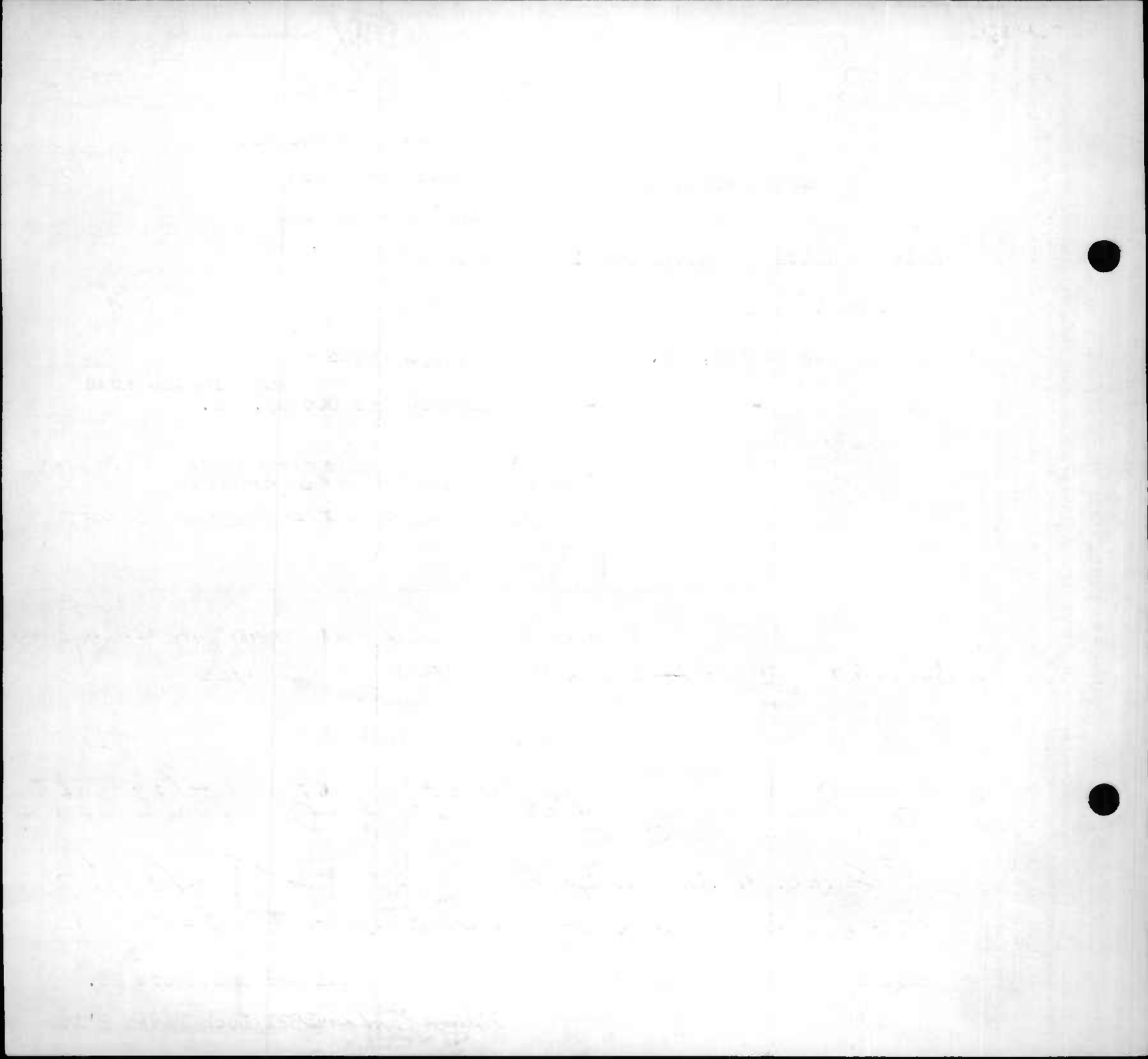
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 4361 | |
|---|---------|--|---|--|--------------------------------|
| BIRTH NO. 67 4361 | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | BENNETT, David James | | April 28, 1967 10:00 P M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | A. STATE B. COUNTY | | |
| Veterans Administration Hospital | | | Pennsylvania Chester | | |
| 3900 Loch Raven Blvd. | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | |
| Baltimore, Maryland 21218 | | | Avondale | | |
| | | | D. STREET ADDRESS (If rural, give location) | | |
| | | | P.O. Box 242 | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. If Under 1 Yr. Months Days |
| Male | White | Married | 2/15/13 | 54 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? |
| Truck Driver | | | Tennessee | | U.S.A. |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| James Bennett | | | Bertha Brummit | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS | | |
| Yes 12/7/42 to 12/18/44 | | 169-18-2835 | Records Veterans Administration Hosp. Baltimore, Md. | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | CAUSE OF DEATH | | |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | | (A) DUE TO | | |
| Probable pulmonary embolus | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| ANTECEDENT CAUSES | | | (B) DUE TO | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | Malnutrition | | |
| | | | (C) DUE TO | | |
| | | | Chronic alcoholism | | |
| | | | Many years | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nately medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | |
| 22. I certify that (1) (this hospital) attended the deceased from April 28 19 67 to April 28 19 67, that (2) (we) last saw the deceased alive on April 28 19 67 and that in (3) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| <i>Allen Johnson</i> | | | | 4-29-67 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| ALLEN JOHNSON | | | | Veterans Administration Hosp., Balto. Md. 21218 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | May 1, 1967 | | Union Hill Cemetery | |
| | | | | Kennett Square, Pa. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| MAY 3 1967 | | <i>Robert E. Johnson</i> | | <i>William E. Johnson</i> | |
| | | | | 8521 Loch Raven Blvd. Balto., Md. 21204 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 4362 | |
|---|----------------------|---|---------------------------------|--|--|
| BIRTH NO. 67 4362 | | M.E. CASE NO. 67 4362 | | 1. NAME OF DECEASED (Type or Print) <u>RICHARD L. COCKEY, JR.</u> | |
| 2. DATE AND HOUR OF DEATH <u>4/29/67</u> | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| 37 Mercy Hospital | | A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore Co.</u> | | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | D. STREET ADDRESS (If rural, give location) | | | |
| <u>Baltimore 21204</u> | | <u>1615 Yakona Road</u> | | | |
| 5. SEX <u>Male</u> | 6. RACE <u>White</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Never married</u> | 8. DATE OF BIRTH <u>7/29/53</u> | 9. AGE (In years last birthday) <u>13</u> | (If Under 1 Yr. Months: Days: (If Under 24 Hrs. Hours: Min.) |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13. FATHER'S NAME <u>Richard Lee Cockey, Sr.</u> | | 14. MOTHER'S MAIDEN NAME <u>Evelyn Beebe</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>-</u> | | 17. INFORMANT <u>Richard Lee Cockey, Sr.</u> ADDRESS <u>1615 Yakona Road</u> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| I | | (A) <u>MYOCARDITIS + HEPATITIS WITH PASSIVE CONGESTION OF LIVER + SPLEEN</u> | | <u>1-2 WKS</u> | |
| II | | (B) <u>OVERWHELMING VIRAL INFECTION</u> | | <u>2 WKS</u> | |
| DUE TO | | (C) | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | III | | <u>1-2 WKS</u> | |
| 19A. DATE OF OPERATION <u>4/28/67</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>BIOPSY</u> | | 20A. AUTOPSY? (Yes or No) <u>YES</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED White At <input type="checkbox"/> Work Not White At <input type="checkbox"/> Work | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from <u>4/25</u> 19 <u>67</u> to <u>4/29</u> 19 <u>67</u> . | | that (2) (we) last saw the deceased alive on <u>4/29</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (3) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE <u>S. Bruce Garber, M.D.</u> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <u>4/29/67</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>S. BRUCE GARBOR</u> | | 23D. ADDRESS <u>8045 WOODGATE CT., BALTO., MD.</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>5/2/67</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial Park</u> | |
| 24D. LOCATION <u>Baltimore Baltimore Md.</u> | | 25A. DATE REC'D BY HEALTH DEPT. <u>MAY 3 1967</u> | | | |
| 25B. NAME OF REGISTRAR <u>Robert E. Taylor</u> | | 25C. FUNERAL DIRECTOR <u>William J. Johnson</u> ADDRESS <u>8521 Loch Raven B'ldg.</u> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 67 4363 | |
|--|---------------------|---|--|--|---|
| CERTIFICATE OF DEATH | | | | Registered No. 67 4363 | |
| BIRTH NO. 67 4363 | | M.E. CASE NO. | | 2. DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED
(Type or Print) Chester L Houtz | | May 1, 1967 M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
So Baltimore Gen Hospital | | A. STATE Md
B. COUNTY | | | |
| CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | | D. STREET ADDRESS (If rural, give location)
4024-8th St | | | |
| 5. SEX
Male | 6. RACE
W | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married | 8. DATE OF BIRTH
Oct 5, 1903 | 9. AGE (In years last birthday)
63 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| | | | | Penna | |
| 13. FATHER'S NAME
Claire Houtz | | 14. MOTHER'S MAIDEN NAME
Bertha Reed | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Family | |
| ADDRESS
Same | | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)
3-27-11 | | CAUSE OF DEATH
(A) Longestive heart failure
(B) Cor pulmonale
(C) Emphysema, Bronchial asthma | | INTERVAL BETWEEN ONSET AND DEATH
7 years | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from March 2 1960 to April 26 1967 , that (I) (we) last saw the deceased alive on April 26 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Imre Neubauer M.D. | | | | 23B. DATE SIGNED
May 2, 1967 | |
| 23C. PHYSICIAN'S NAME (Type)
IMRE NEUBAUER M.D. | | | | 23D. ADDRESS
936 Patapsco Ave. Balto. Md | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
5/5/67 | | 24C. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cem | |
| 24D. LOCATION
AA Co | | 24E. STATE
Md | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 3 1967 | | 25B. NAME OF REGISTRAR
Robert E. Taylor | | 25C. FUNERAL DIRECTOR
McCully F H 237 Patapsco Ave 21225 | |
| ADDRESS
21225 | | | | | |

1000

1000

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | | | | | | | | |
|--|---------|--|--|--|--|---|-------------------------------------|---|--|
| BIRTH NO. | | 67 4364 | | Registered No. | | 67 4364 | | | |
| M.E. CASE NO. | | | | 1. NAME OF DECEASED
(Type or Print) | | | | | |
| | | | | EDWARD BALTIMORE | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 2. DATE AND HOUR OF DEATH | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location) | | | | A. STATE | | | | | |
| | | | | MARYLAND | | | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | | | |
| THE JOHNS HOPKINS HOSPITAL | | | | BALTIMORE | | | | | |
| | | | | D. STREET ADDRESS (If rural, give location) | | | | | |
| | | | | 1515 NORTH DALLAS STREET | | | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH | | 9. AGE (In years
last birthday) | | 10. Under 1 Yr.
Months Days Hours Mln. | |
| MALE | COLORED | WIDOWER | | 9-1-94 | | 72 | | | |
| 10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | | 12. CITIZEN OF
WHAT COUNTRY? | | |
| Laborer | | Gov't | | Maryland | | | | | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | | | |
| Unknown | | | | Unknown | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL
SECURITY NO. | | 17. INFORMANT | | | |
| Yes | | | | WWI | | Mildred Jones 2233 E. Biddle St. | | | |
| 18. CAUSE OF DEATH | | | | DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH | | | INTERVAL BETWEEN
ONSET AND DEATH | | |
| | | | | (A) DUE TO | | | Card resp. arrest | | |
| | | | | (B) DUE TO | | | meningitis | | |
| | | | | (C) DUE TO | | | pneumonia | | |
| | | | | II | | | | | |
| | | | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH? | | | |
| 2 | | | | Yes | | NO | | | |
| 21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.) | | 21C. WHERE DID
INJURY OCCUR? | | (If in Baltimore City, give exact location) | | | |
| | | | | | | | | | |
| 21D. TIME
OF INJURY
(APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | | | |
| (Month) (Day) (Year) (Hour) | | While At <input type="checkbox"/> Not While <input type="checkbox"/>
Work At Work | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 4/30 19 67 to 5/1 19 67,
that (I) (we) last saw the deceased alive on 5/1 19 67 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | | | | |
| I. Ismail Beigi | | | | 5/1/67 | | | | | |
| 23C. PHYSICIAN'S
NAME (Type) | | | | 23D. ADDRESS | | | | | |
| ISMAIL -BEIGI, | | | | M.D. JOHNS HOPKINS HOSPITAL | | | | | |
| 24A. BURIAL CREMATION,
REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | | | |
| Burial | | 5/4/67 | | Balto National Cem. | | Balto., Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | | | |
| MAY 3 1967 | | Robert E. Taylor | | Wm C March | | 928 E. North Ave. | | | |

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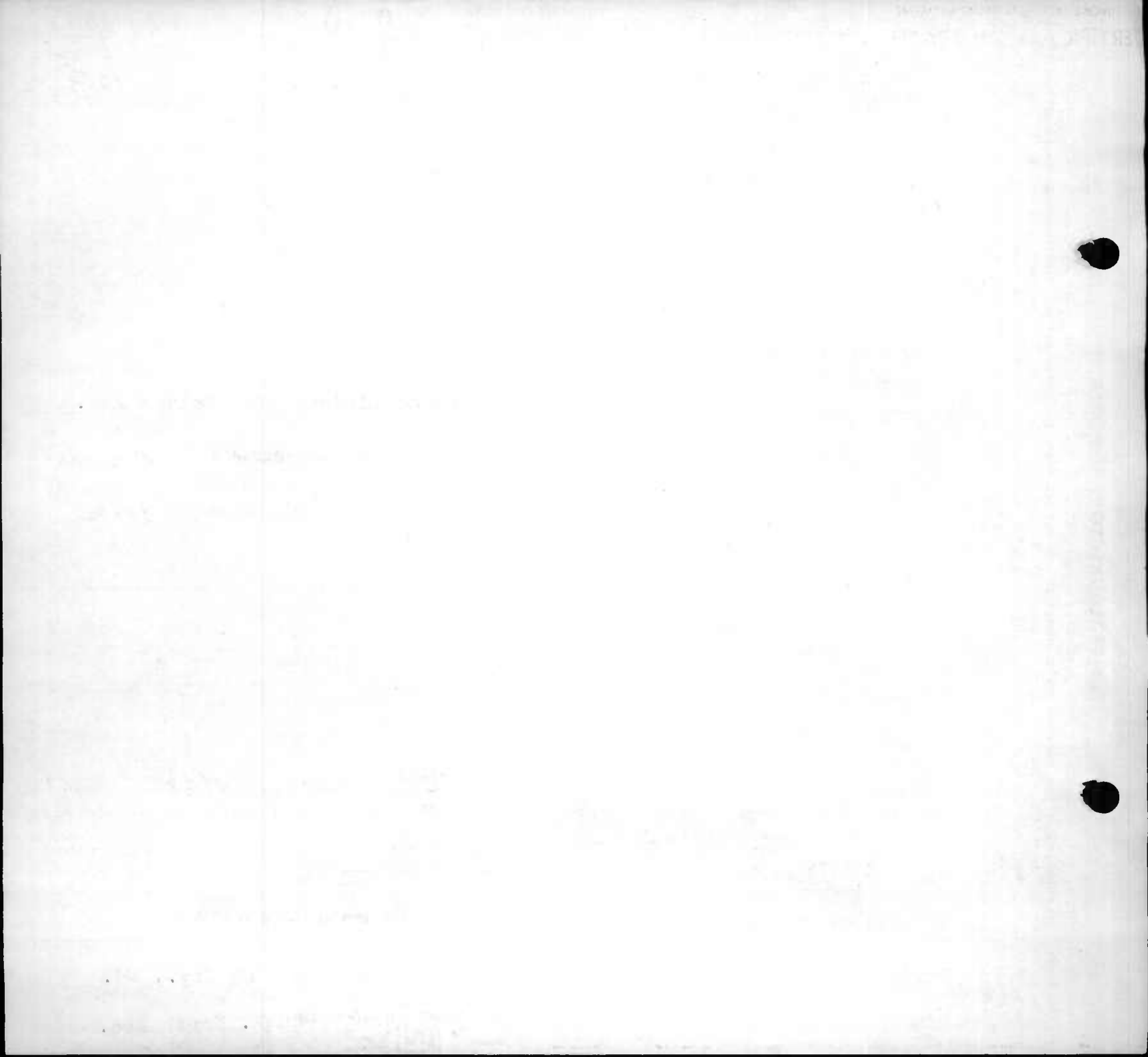
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|--|----------------------------------|--|------------------------|--|
| BIRTH NO. 67 4365 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 4365 | |
| M.E. CASE NO. | | | 1. NAME OF DECEASED (Type or Print) GROSS, JOHN | | |
| 2. DATE AND HOUR OF DEATH 4/28/67 | | | 10 ⁴⁵ _{PM} M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
LUTHERAN HOSPITAL
46 | | | A. STATE MD
B. COUNTY | | |
| 5. SEX M | | | 6. RACE C | | |
| 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
SEPARATED | | | 8. DATE OF BIRTH 4/2/01 | | |
| 9. AGE (In years lost birthday) 66 | | | 10. Under 1 Yr. Months: Ooys: Hours: Min. | | |
| 11. BIRTHPLACE (State or foreign country)
CALVERT CO, Md | | | 12. CITIZEN OF WHAT COUNTRY? | | |
| 13. FATHER'S NAME
John Gross Sr | | | 14. MOTHER'S MAIDEN NAME | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | |
| 17. INFORMANT | | | ADDRESS
Vernice Lindsay 3301 Batman Ave. | | |
| 18. 351X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
CEREBRO VASCULAR HEMORRAGE
DUE TO
ARTERIOSCLEROTIC VASC. DISEASE
YEARS
INTERVAL BETWEEN ONSET AND DEATH
5 weeks | | | | | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| 20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 21A. DATE OF OPERATION | | | 21B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | |
| 21C. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21D. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | |
| 21E. TIME OF INJURY (Month) (Day) (Year) (Hour) | | | 21F. HOW DID INJURY OCCUR? | | |
| 21G. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 4/3 19 67 to 4/28 19 67 , that (I) (we) last saw the deceased alive on 4/28 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE F. Quedal | | | 23B. DATE SIGNED 4/28/67 | | |
| 23C. PHYSICIAN'S NAME (Type)
FERNANDO QUEDAL | | | 23D. ADDRESS
LUTHERAN HOSPITAL | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | | 24B. DATE
5/5/67 | | |
| 24C. NAME of CEMETERY or CREMATORY
Mt Calvary Cemetery | | | 24D. LOCATION (City, town, or county) (State)
Anne Arundel Cty., Md. | | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 3 1967 | | | 25B. NAME OF REGISTRAR
Robert E. Tuley | | |
| 25C. FUNERAL DIRECTOR
Wm C March | | | ADDRESS
928 E. North Ave. | | |

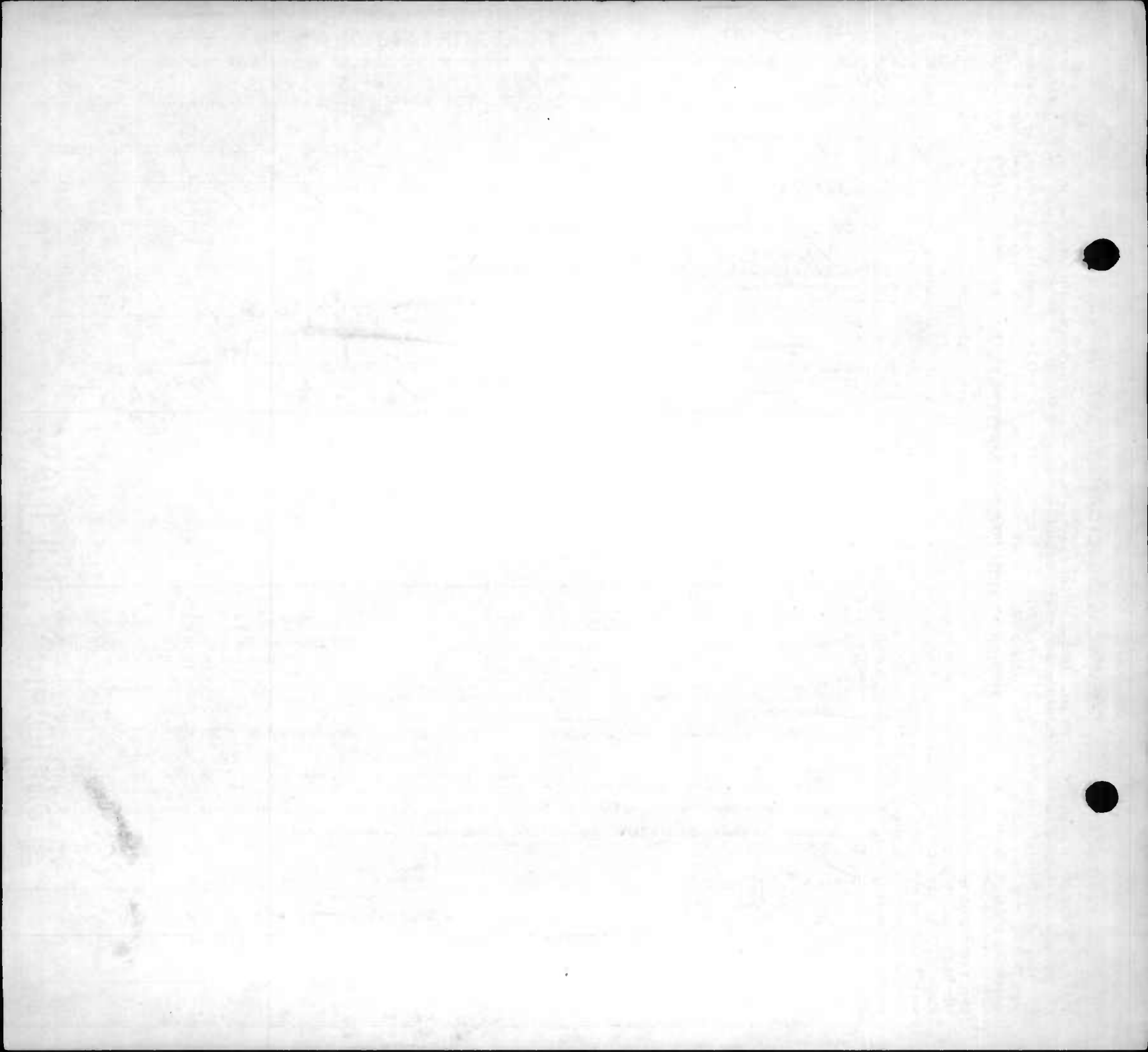


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 67 4366 | | BALTIMORE CITY HEALTH DEPARTMENT 34-68-13 | | Registered No. 67 4366 | |
|---|--|---|---|--|--|
| M.E. CASE NO. | | | CERTIFICATE OF DEATH | | |
| 1. NAME OF DECEASED
(Type or Print) <i>Mabel Dorsey</i> | | | 2. DATE AND HOUR OF DEATH
<i>5/1/67</i> <i>1:40</i> a.m. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<i>38 University Hospital</i> | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE <i>md</i> B. COUNTY _____ | | |
| 5. SEX <i>F</i> 6. RACE <i>Negro</i> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>widow</i> | | | 8. DATE OF BIRTH <i>1/4/98</i> 9. AGE (In years last birthday) <i>69</i> | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 11. BIRTHPLACE (State or foreign country) <i>Weems, Virginia</i> | | |
| 10B. KIND OF BUSINESS OR INDUSTRY _____ | | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | |
| 13. FATHER'S NAME _____ | | | 14. MOTHER'S MAIDEN NAME <i>Lizurk D. Fisher</i> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) _____ | | | 16. SOCIAL SECURITY NO. _____ | | |
| 17. INFORMANT <i>daughter</i> ADDRESS <i>1047 Brantley Ave</i> | | | 18. CAUSE OF DEATH | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
<i>septic shock</i>
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
<i>pneumonia & peritonitis</i> | | | INTERVAL BETWEEN ONSET AND DEATH
<i>24 hrs</i> | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
<i>intestinal obstruction 2° to Carcinoma of colon</i> | | | | | |
| 19A. DATE OF OPERATION <i>4/29</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
<i>intestinal obstruction</i> | | 20A. AUTOPSY? (Yes or No) _____ | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? _____ | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____ | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____ | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) _____ | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? _____ | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>4/29</i> <i>1967</i> to <i>5/1</i> <i>1967</i> , that (I) (we) last saw the deceased alive on <i>5/1/67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Robert M. Byers</i> M.D. | | | | 23B. DATE SIGNED <i>5/1/67</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>Robert M. BYERS</i> | | | | 23D. ADDRESS <i>University Hospital</i> M.D. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i> | | 24B. DATE <i>5-3-67</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>Mount Auburn Cem.</i> | |
| 24D. LOCATION (City, town, or county) <i>Balto.</i> | | 24E. LOCATION (State) <i>Md.</i> | | | |
| 25A. DATE REC'D. BY HEALTH DEPT. <i>MAY 3 1967</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Taylor</i> | | 25C. FUNERAL DIRECTOR <i>Mortons, Dyett F.H.</i> ADDRESS <i>1701 Laurens</i> | |



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BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. **67 4367** MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. **67 4367**

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) **BENNIE A. AVERY** 2. DATE AND HOUR PRONOUNCED DEAD **4-30-67 7:50 PM M.**

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD **BON SECOUR HOSPITAL** 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) **Maryland**

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) **BON SECOUR HOSPITAL** 5. A. STATE **Maryland**

6. CITY OR TOWN (If outside corporate limits, write RURAL and give township) **Baltimore** 7. B. COUNTY **20-04**

8. STREET ADDRESS (If rural, give location) **2510 Emerson Street**

9. SEX **Male** 10. RACE **Colored** 11. 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) **1-8-1942** 12. 9. AGE (In years last birthday) **25** 13. If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

14. 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **CHAUFFER** 15. 10B. KIND OF BUSINESS OR INDUSTRY **MARION, NORTH CAROLINA** 16. 12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

17. 13. FATHER'S NAME **SAMUEL AVERY** 18. 14. MOTHER'S MAIDEN NAME **ANNA MINOR**

19. 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) **219-38-3453** 20. 16. SOCIAL SECURITY NO. **Mrs. Zelline Avery 2510 Emerson Street**

21. 17. INFORMANT **Mrs. Zelline Avery** 22. ADDRESS **2510 Emerson Street**

23. 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH **CAUSE OF DEATH** 24. INTERVAL BETWEEN ONSET AND DEATH

25. (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) **Massive internal bleeding**

26. ANTECEDENT CAUSES **Gunshot wound of chest involving heart and lung**

27. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

28. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

29. 19A. DATE OF OPERATION **19-04-67** 30. 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED **Bar** 31. 20A. AUTOPSY? (Yes or No) **Yes** 32. 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? **20-04**

33. 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. **Bar** 34. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) **Subway Bar** 35. 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) **2201 W. Baltimore Street**

36. 21D. TIME OF INJURY (APPROX.) **4 30 '67 7:05 PM** 37. 21E. INJURY OCCURRED **WHILE AT WORK** **NOT WHILE AT WORK** **Shot by another patron** 38. 21F. HOW DID INJURY OCCUR? **Was a patron in bar.**

39. 22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐

40. ACTUAL SIGNATURE **Werner U. Spitz** 41. CHIEF MEDICAL EXAMINER ☐ 42. DATE SIGNED **5-1-67**

43. EXAMINER'S NAME (Type) **WERNER U. SPITZ, M.D.** 44. ASSISTANT MEDICAL EXAMINER ☒ 45. ASSOCIATE MEDICAL EXAMINER ☐

46. 23A. BURIAL CREMATION, REMOVAL (Specify) **BURIAL** 47. 23B. DATE **5-4-67** 48. 23C. NAME OF CEMETERY or CREMATORY **Arbutus Mem. Park** 49. 23D. LOCATION (City, town, or county) (State) **Arbutus, Maryland**

50. 24A. DATE REC'D BY HEALTH DEPT. **MAY 3 1967** 51. 24B. NAME OF REGISTRAR **Robert E. Taylor** 52. 24C. FUNERAL DIRECTOR ADDRESS **MORTON & DYETT F.H. 1701 Laurens**

53. VS 151-REV. 1/1/65 **1579.4 9670004375**

WALTERS FORGE

WALTERS FORGE

2-3

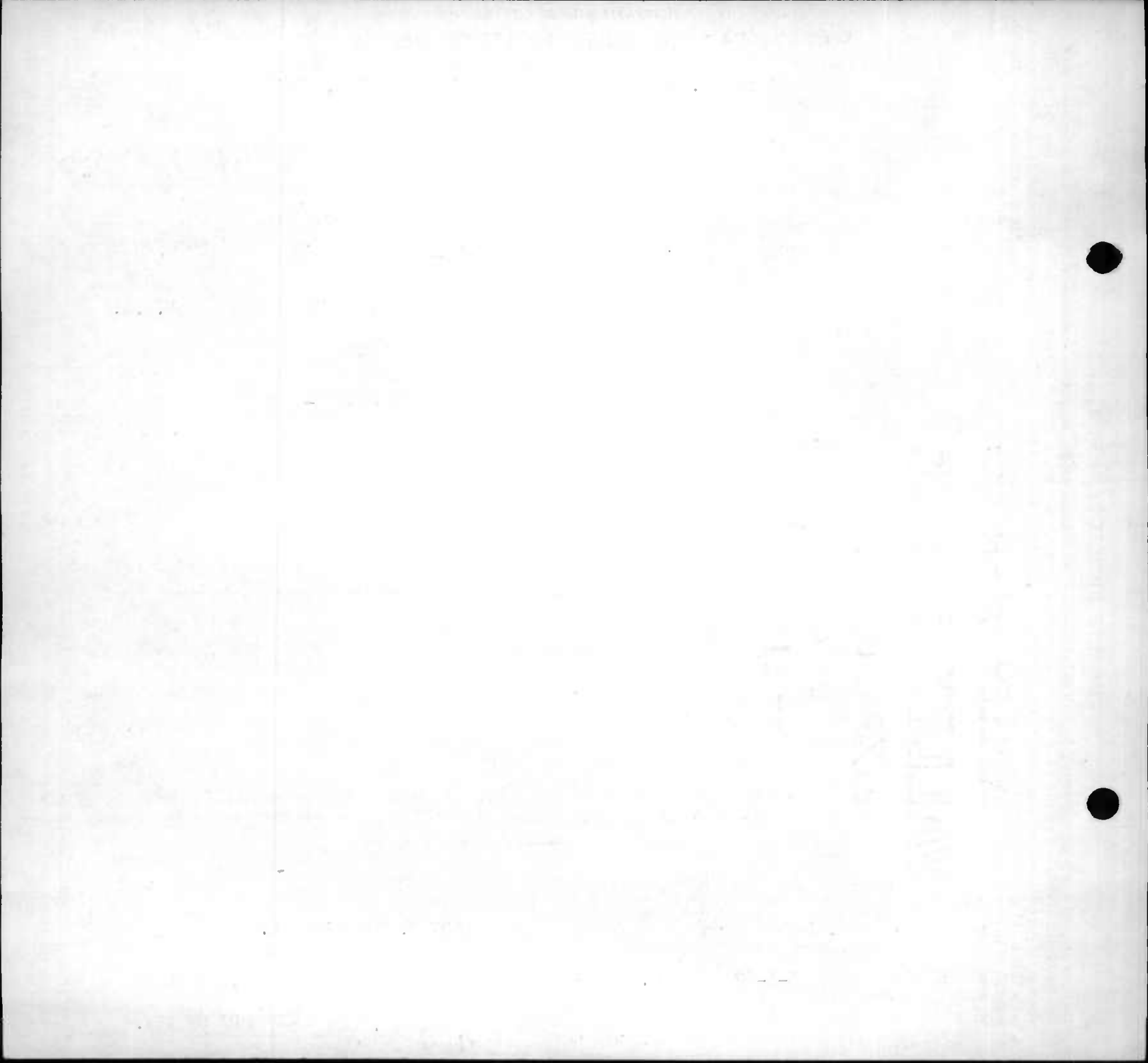
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 67 4368 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 4368 | |
|--|--------------------|--|---|---|---|--|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) MYRTLE B. JONES | | | | 2. DATE AND HOUR OF DEATH
MAY 2, 1967 M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

00 800 GEORGE STREET | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE
D. STREET ADDRESS (If rural, give location)
800 GEORGE STREET | | | |
| 5. SEX
FEMALE | 6. RACE
COLORED | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
MARRIED | 8. DATE OF BIRTH
7-19-1906 | 9. AGE (In years lost birthday)
60 | If Under 1 Yr.
Months Days | If Under 24 Hrs.
Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
BALTIMORE, MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
NICHOLAS BIDDLE | | | 14. MOTHER'S MAIDEN NAME
EMMA THOMAS | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
RANDOLPH JONES - 800 GEORGE STREET | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
334X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH
(A) DUE TO Cerebral-afopleury
(B) DUE TO Hypertension
(C) | | INTERVAL BETWEEN ONSET AND DEATH
3 days
2-3 years | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from April 30 1967 to May 2 1967, that (I) (we) last saw the deceased alive on May 2 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
Wm. LeRoy Berry | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
5-3-67 | |
| 23C. PHYSICIAN'S NAME (Type)
Wm. LeRoy Berry | | | | 23D. ADDRESS
M.D. 1237 N. Caroline St. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
5-6-67 | | 24C. NAME OF CEMETERY or CREMATORY
MT. AUBURN | | 24D. LOCATION (City, town, or county) (State)
BALTIMORE, MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 4 1967 | | 25B. NAME OF REGISTRAR
Charles E. Taylor | | 25C. FUNERAL DIRECTOR ADDRESS
CHARLES R. LAW 802 MADISON AVE. | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 4369 | |
|---|---------|---|------------------------------|--|--|
| <div style="display: flex; justify-content: space-between;"> 67 4369 CERTIFICATE OF DEATH </div> | | | | | |
| BIRTH NO. | | M.E. CASE NO. | | | |
| 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| MILLER J. LEE | | 5/1/67 11:15 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location) | | A. STATE
B. COUNTY | | | |
| LUTHERAN HOSPITAL
46 | | Md.
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE 15-09
D. STREET ADDRESS (If rural, give location)
2311 MONTICELLO Rd. | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| M | C | MARRIED | 7/15/13 | 53 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Laborer | | Steel Mill | | Baltimore, Maryland | |
| 13. FATHER'S NAME | | | 12. CITIZEN OF WHAT COUNTRY? | | |
| Turner Lee | | | U.S.A. | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS |
| Yes WW II | | | 212-12-1162 | | Mary E. Lee - 2311 Monticello Rd. |
| 18. 331X I | | CAUSE OF DEATH | | | INTERVAL BETWEEN ONSET AND DEATH |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) ARTERIAL CEREBRAL HEMORRHAGE | | | 7 days |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) ARTERIOSCLEROSIS | | | YEARS |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | (C) | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 2 | | | | YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 4-24-1967 to 5-1-1967, that (I) (we) last saw the deceased alive on 5-1-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| F. Quera | | | | 5-1-67 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| FERNANDO QUERA | | LUTHERAN HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | |
| Burial | | 5-6-67 | | Arbutus Memorial Park | |
| | | | | Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| MAY 4 1967 | | Charles R. Law | | 802 Madison Ave. | |

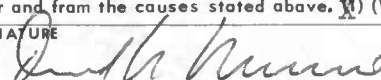
1913

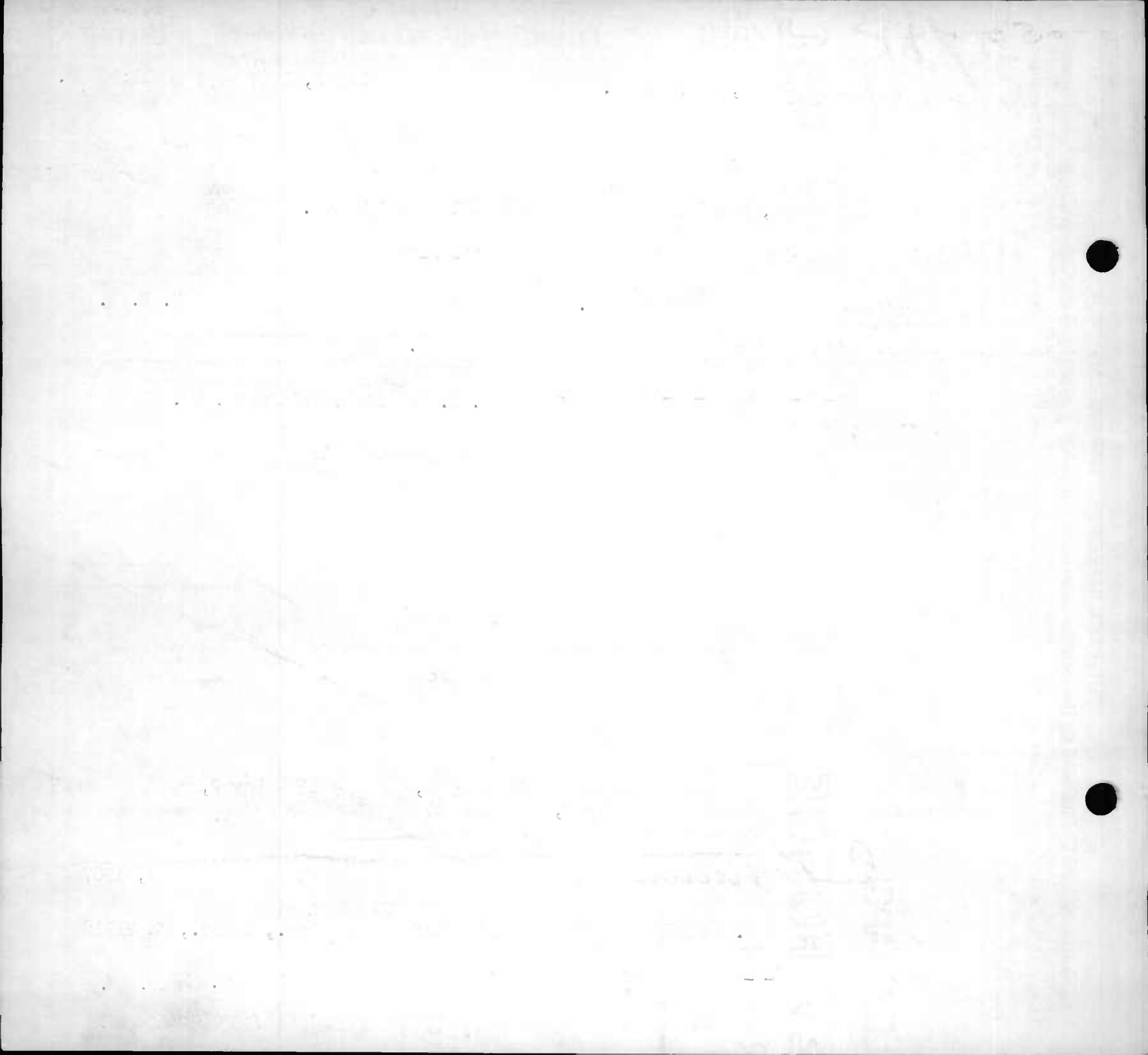
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1913

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|-----------------------------|---|--|--|--|--|--|--|--|
| 67 4370 | | | | | 67 4370 | | | | |
| BIRTH NO. | | | | | CERTIFICATE OF DEATH | | | | |
| M.E. CASE NO. | | | | | Registered No. | | | | |
| 1. NAME OF DECEASED
(Type or Print) GEISENDAFFER, Lawrence A. | | | | | 2. DATE AND HOUR OF DEATH
May 2, 1967 11:30 P. <small>M.</small> | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE Maryland B. COUNTY Baltimore | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
27 Veterans Administration Hospital
3900 Loch Raven Boulevard
Baltimore, Maryland 21218 | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location)
6119 Cardiff Ave. | | | | |
| 5. SEX
Male | 6. RACE
Caucasian | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married | 8. DATE OF BIRTH
11-10-18 | 9. AGE (In years lost birthday)
48 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Chauffeur | | | 10B. KIND OF BUSINESS OR INDUSTRY
Taxi Cab Co. | | 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | | |
| 13. FATHER'S NAME
Robert Geisendaffer | | | | | 14. MOTHER'S MAIDEN NAME
Mary F. Berger | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
Yes 8-23-43 to 10-18-45 | | | 16. SOCIAL SECURITY NO.
212-10-8155 | | 17. INFORMANT
Records | | ADDRESS
V. A. Hospital, Baltimore, Md. 21218 | | |
| 18. 002.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Pulmonary Tuberculosis
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | CAUSE OF DEATH
(A) DUE TO
(B) DUE TO
(C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH
5 years | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Duodenal Ulcer | | | | | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from February 2, 1967 to May 2, 1967 , that XX (we) last saw the deceased alive on May 2, 1967 and that in XX (our) opinion death occurred on the date and hour and from the causes stated above. XX (We) (did) not view the body after death. | | | | | | | | | |
| 23A. SIGNATURE

M.D. | | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
May 3, 1967 | | |
| 23C. PHYSICIAN'S NAME (Type)
DAVID N. MARINE | | | | | 23D. ADDRESS
M.D. VA Hospital
3900 Loch Raven Blvd., Balto., Md 21218 | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
5-5-67 | | 24C. NAME OF CEMETERY or CREMATORY
Baltimore National Cemetery | | 24D. LOCATION (City, town, or county) (State)
Frederick Ave. Balto. Md | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 4 1967 | | 25B. NAME OF REGISTRAR
P. G. E. Thompson | | 25C. FUNERAL DIRECTOR
Thomas J. Henry Inc 1600 Hollins St | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | |
|--|---------------------|--|---|---|--|--|--|--|--|--|
| CERTIFICATE OF DEATH | | | | | Registered No. <u>67 4371</u> | | | | | |
| BIRTH NO. <u>Washington D.C. 67 4371</u> | | | | | M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED
(Type or Print) Timothy Wayne Kruer | | | | | 2. DATE AND HOUR OF DEATH
May 2, 1967 2:30 P.M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE DC
B. COUNTY | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
US Public Health Service Hospital
Wyman Pk. Drive & 31st Street | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Washington | | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location)
613 Hamlin Street, Apt. 5 NE | | | | | |
| 5. SEX
M | 6. RACE
W | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Child | 8. DATE OF BIRTH
1/12/65 | 9. AGE (In years last birthday)
2 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Child | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
DC | | 12. CITIZEN OF WHAT COUNTRY?
USA | | | |
| 13. FATHER'S NAME
Melvin Kruer | | | 14. MOTHER'S MAIDEN NAME
Diana Lickteig | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
no | | | 16. SOCIAL SECURITY NO.
none | | 17. INFORMANT ADDRESS
Records- US PHS Hospital, Balto, Md. | | | | | |
| 18. 204.3 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osteonia, etc. It means the disease, injury or complication which caused death.)
Acute passive congestion
(A) DUE TO
Acute lymphatic leukemia
(B) DUE TO
(C) _____
INTERVAL BETWEEN ONSET AND DEATH
Days
10 mos. | | | | | | | | | | |
| 19. DATE OF OPERATION
2 | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Mar. 24 19 67 to May 2 19 67 , that (I) (we) lost saw the deceased alive on May 2 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | |
| 23A. SIGNATURE
<i>Michael E. Pelczar</i> | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
5/3/67 | | | |
| 23C. PHYSICIAN'S NAME (Type)
Michael E. Pelczar, SA Surg (R) | | | | | 23D. ADDRESS
M.D. US PHS Hospital, Balto, Md. | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
5/5/67 | | 24C. NAME OF CEMETERY or CREMATORY
St. John's | | 24D. LOCATION (City, town, or county) (State)
Starlight, Indiana | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 4 1967 | | | 25B. NAME OF REGISTRAR
<i>Robert E. Taylor</i> | | | 25C. FUNERAL DIRECTOR
Wm. Cook-Brooks Inc. Baltimore, Md. 21202 | | | ADDRESS | |

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67 4372

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 4372

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

PAT AMBROSE

2. DATE AND HOUR PRONOUNCED DEAD

5-1-67 2:15 PM M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

2800 REISTERSTOWN ROAD - Amb. Crew #14

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2800 Reisterstown Road - Apt. #7

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

W.

8. DATE OF BIRTH

6/14/1900

9. AGE (In years
last birthday)

66

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Mississippi

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

WWII

16. SOCIAL
SECURITY NO.

438-14-5234

17. INFORMANT

Records

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT NOT WHILE
m. WORK AT WORK

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

WERNER U. SPITZ, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

5-2-67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

5/5/67

23C. NAME OF CEMETERY or CREMATORY

Baltimore National

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

MAY 4 1967

24B. NAME OF REGISTRAR

Robert E. Farley

24C. FUNERAL DIRECTOR

ADDRESS

Charles A. Rice 661 W. Barre St.

WATKINS FORD

WATKINS FORD

1
L-246

67 4373

BALTIMORE CITY HEALTH DEPARTMENT

67 4373

BIRTH NO. 60-15165 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) MARY I. LOCKLEAR 2. DATE AND HOUR PRONOUNCED DEAD 4-30-67 10:15 AM M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

35 CHURCH HOME AND HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

20 S. Chester Street

5. SEX Female 6. RACE American Indian 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) Single 8. DATE OF BIRTH June 7, 1960 9. AGE (In years last birthday) 6

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student 10B. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Clyde L. Locklear 14. MOTHER'S MAIDEN NAME Mary Postanowicz

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT Mrs. Mary Locklear 20 S. Chester Street ADDRESS

18. CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) Gunshot wound of head DUE TO

ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 2 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) Yes 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) House 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 2209 E. Baltimore Street - 3rd floor

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Minute) 4 27 '67 5:25 PM m. 21E. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21F. HOW DID INJURY OCCUR? Shot in head

22. I certify that I held an Inquiry Inspection Autopsy and that on this basis, death in my opinion resulted from: Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL SIGNATURE EXAMINER'S NAME (Type) WERNER U. SPITZ, M.D. CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER ASSOCIATE MEDICAL EXAMINER

DATE SIGNED 5-1-67

23A. BURIAL CREMATION, REMOVAL (Specify) Burial 23B. DATE May 2-1967 23C. NAME OF CEMETERY or CREMATORY Holy Rosary 23D. LOCATION (City, town, or county) (State) Baltimore County, Maryland

24A. DATE REC'D BY HEALTH DEPT. MAY 4 1967 24B. NAME OF REGISTRAR 24C. FUNERAL DIRECTOR ADDRESS Lilly & Zeiler Inc. 1901-07 Eastern Ave.



3% NO. 1000000

1000000 1000000

June 1, 1960

Salisbury, Maryland

Very Respectfully

Wm. W. Sullivan

Commissioner of the

Salisbury, Maryland

Wm. W. Sullivan

1
P-235

67 4374

BALTIMORE CITY HEALTH DEPARTMENT

67 4374

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

| | | | | | | | |
|--|-------------------------|--|--|--|--|--|--|
| 1. NAME OF DECEASED
(Type or Print)
WILLIAM E. POSTANOWICZ | | | | 2. DATE AND HOUR PRONOUNCED DEAD
April 27, 1967 5:50 P. M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
35 99 Church Home Hospital (DOA) | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY 1-05
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
2209 E. Baltimore Street | | | |
| 5. SEX
Male | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Single | 8. DATE OF BIRTH
Sept. 16, 1948 | | 9. AGE (In years last birthday)
18 | 10. If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Student | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Baltimore, Maryland | | |
| 13. FATHER'S NAME
Walter Postanowicz | | | 14. MOTHER'S MAIDEN NAME
Ida Cymek | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
Mrs. Ida Sizemore 2209 E. Baltimore Street | | |
| 18. E 976X
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
Contact gunshot wound of anterior trunk with perforations of heart, liver and aorta | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | (B) DUE TO
(C) | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
Yes | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
home | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
2209 E. Baltimore St. 1-05 | | | |
| 21D. TIME OF INJURY (APPROX.)
4-27-67 5:15 P. | | 21E. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR?
Shot self | | | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>
CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>
ACTUAL SIGNATURE Charles S. Springate M.D.
EXAMINER'S NAME (Type) Charles S. Springate, M.D. | | | | | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 23B. DATE
5-2-1967 | | 23C. NAME OF CEMETERY or CREMATORY
Holy Rosary | | 23D. LOCATION (City, town, or county) (State)
Baltimore County, Maryland | |
| 24A. DATE REC'D BY HEALTH DEPT.
MAY 4 1967 | | 24B. NAME OF REGISTRAR
Robert E. Farley | | 24C. FUNERAL DIRECTOR ADDRESS
Lilly & Zeiler Inc. 1901-07 Eastern Ave. | | | |

N 87949670004382

WATERBURY, CONNECTICUT

WATERBURY, CONNECTICUT

WATERBURY, CONNECTICUT

B-63067 4375

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 67 4375

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Barrette, Lem (Lem Barrett)

2. DATE AND HOUR OF DEATH

May 2, 1967 2:10 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland #21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland, Baltimore Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

111 Selfridge Rd. #21220 005

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

1-20-1881

9. AGE (In years
lost birthday)

86

If Under 1 Yr.
Months DaysIf Under 24 Hrs.
Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Farmer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

West Virginia

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

David Barrette

14. MOTHER'S MAIDEN NAME

Sarah (unknown)

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

unknown

17. INFORMANT

BC# 4940 Eastern Avenue
Baltimore, Maryland #21224

18.

422.1 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, osthenia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) DUE TO

Cerebro-vascular accident 4 wks

(B) DUE TO

Generalized A.S.C.V.D.

(C) DUE TO

evolving to present

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Aspiration pneumonia

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐ Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (H) (this hospital) attended the deceased from 4/15 19 67 to 5/2 19 67,
that (W) (we) last saw the deceased alive on 5/2 19 67 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Carl Winterstein

M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

5/2/67

23C. PHYSICIAN'S
NAME (Type)

Carl Winterstein

M.D.

23D. ADDRESS
BCH 4940 Eastern Avenue Baltimore, Md. #2424A. BURIAL CREMATION,
REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

MAY 4 1967

25B. NAME OF REGISTRAR

R. E. F. F. F.

25C. FUNERAL DIRECTOR

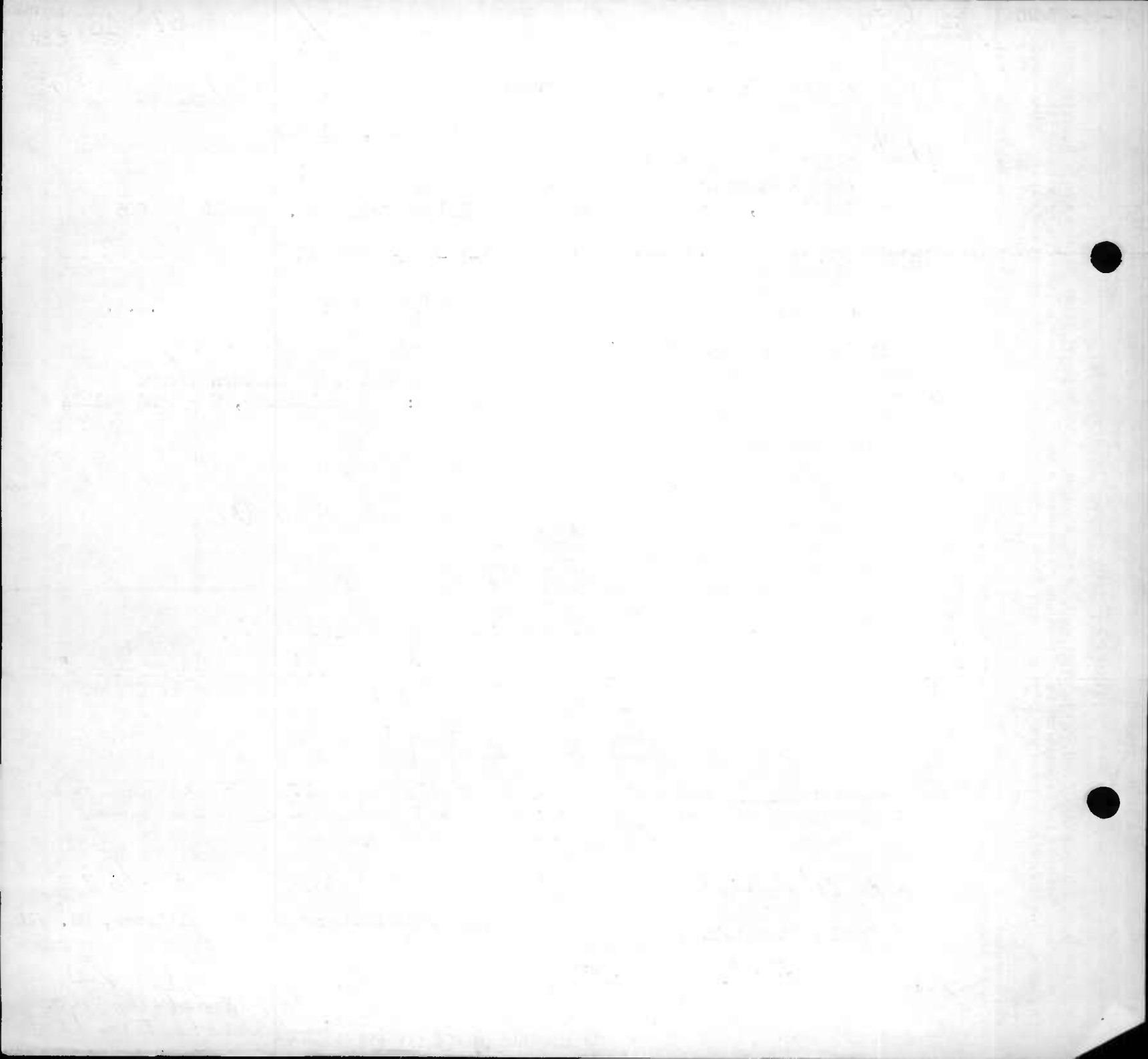
Loring Byer

ADDRESS

8728 Liberty Rd. W. Va. Ronalston Ind.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | |
|---|---------------|--|----------------------------|--|--|--|------------------------------|----------------------------------|--|------------------------|--|
| CERTIFICATE OF DEATH | | | | | | | | | | Registered No. 67 4376 | |
| BIRTH NO. 67 4376 | | | | | | | | | | | |
| M.E. CASE NO. | | | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) Joseph R. Daurer (Joseph R. DAURER) | | 2. DATE AND HOUR OF DEATH 5/1/67 Mon. 5:30 A.M. | | | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 48th Gen'l Hosp | | A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. STREET ADDRESS 2621 Windsor Rd, Parkville | | | | | | | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 2-13-1908 | 9. AGE (In years last birthday) 58 | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Hours: Min. | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman | | 10B. KIND OF BUSINESS OR INDUSTRY Sporting goods | | 11. BIRTHPLACE (State or foreign country) Baltimore, Md | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | |
| 13. FATHER'S NAME Henry J. Daurer | | | | 14. MOTHER'S MAIDEN NAME Regina Krieg | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 216-10-2409 | | 17. INFORMANT Regner M. Daurer - (wife) on Adm | | | | ADDRESS Same | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH (A) Nutritional Cirrhosis - Anasarca (B) Ch. Alcoholism (C) | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| ANTECEDENT CAUSES | | | | | | | | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 3-24-1967 to 5-1-1967, that (I) (we) last saw the deceased alive on 5-1-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE D.H. Conthine | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 5-1-67 | | | | | | | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS M.D. | | | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE Fri May 5-1967 | | 24C. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAY 4 1967 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR 1400 S. CHARLES ST. ADDRESS CURTIS E. EVANS 21230 | | | | | | | |

1870
The first of the year
was a very dry one
and the crops were
very poor.

1871
The first of the year
was a very dry one
and the crops were
very poor.

1872
The first of the year
was a very dry one
and the crops were
very poor.

1873
The first of the year
was a very dry one
and the crops were
very poor.

1874
The first of the year
was a very dry one
and the crops were
very poor.

W-420

| | | | | | |
|---|---------|---|--------------------------|--|---|
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR PRONOUNCED DEAD | |
| | | HELEN E. WELCH | | 5-2-67 10:35 PM M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
43 SOUTH BALTIMORE GENERAL HOSPITAL -DOA
99 | | A. STATE
Maryland
B. COUNTY | | | |
| | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore 24-02 | | | |
| | | D. STREET ADDRESS (If rural, give location)
415 E. Gittings Street 21230 | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min. |
| Female | White | Widow | II/24/1900 | 66 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| None | | | | Maryland | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| Alexander Young | | | Martha J. Mick | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| No | | | | Family - Same | |
| 18. CAUSE OF DEATH | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
422.1 I Arteriosclerotic cardiovascular disease
(A) DUE TO | | | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) DUE TO | | | | | |
| (C) DUE TO | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 0 | | | | No | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| (Month) (Day) (Year) (Hour) | | WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE | | CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED | |
| EXAMINER'S NAME (Type) | | M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | 5-3-67 | |
| RUSSELL S. FISHER, M.D. | | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) | | 23B. DATE | | 23C. NAME OF CEMETERY or CREMATORY | |
| B | | 5/6/67 | | Cedar Hill | |
| 24A. DATE REC'D BY HEALTH DEPT. | | 24B. NAME OF REGISTRAR | | 24C. FUNERAL DIRECTOR ADDRESS | |
| MAY 4 1967 | | R. E. Fisher | | McCully - 130 E. Fort Ave. | |

1 9 6 7 0 0 0 4 3 8 5

WALLEY BROWN

WALLEY BROWN

WALLEY BROWN

BIRTH NO. **67 4378** MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. **67 4378**

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

WILLIAM A. YOUNG

2. DATE AND HOUR PRONOUNCED DEAD

5-2-67

10:15 AM M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)**40**
99 ST. AGNES HOSPITAL - DOA4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

B. COUNTY

Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

2683 Wilkens Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widower

8. DATE OF BIRTH

Jan. 14, 1902

9. AGE (In years
last birthday)

65

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Attendant

10B. KIND OF BUSINESS OR INDUSTRY

Hospital

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Vincent Juskelis

14. MOTHER'S MAIDEN NAME

Antonia Kasper

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

yes

about 1920

16. SOCIAL
SECURITY NO.

216-07-8944

17. INFORMANT

ADDRESS

Miss Victoria Jushelis, 5249 St. Charles Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Arteriosclerotic and hypertensive

~~XXXX~~

cardiovascular disease

(B) DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

WERNER U. SPITZ, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

5-2-67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

5/6/67

23C. NAME OF CEMETERY or CREMATORY

Holy Redeemer Cemetery

23D. LOCATION

(City, town, or county)

Baltimore, Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

MAY 4 1967

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

G. Vernon Lemmon

ADDRESS

4611 Park Heights Ave.

WABALP-1-10-1962

WABALP-1-10-1962

WABALP-1-10-1962

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|---------------------|---|--|---|---|---|-------------------------------------|--|--|
| BIRTH NO. 67 4379 | | | | | CERTIFICATE OF DEATH | | Registered No. 67 4379 | | |
| 1. NAME OF DECEASED
(Type or Print) <i>Fromme - FREDERICK E.</i> | | | | | 2. DATE AND HOUR OF DEATH
<i>5/1/67</i> | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

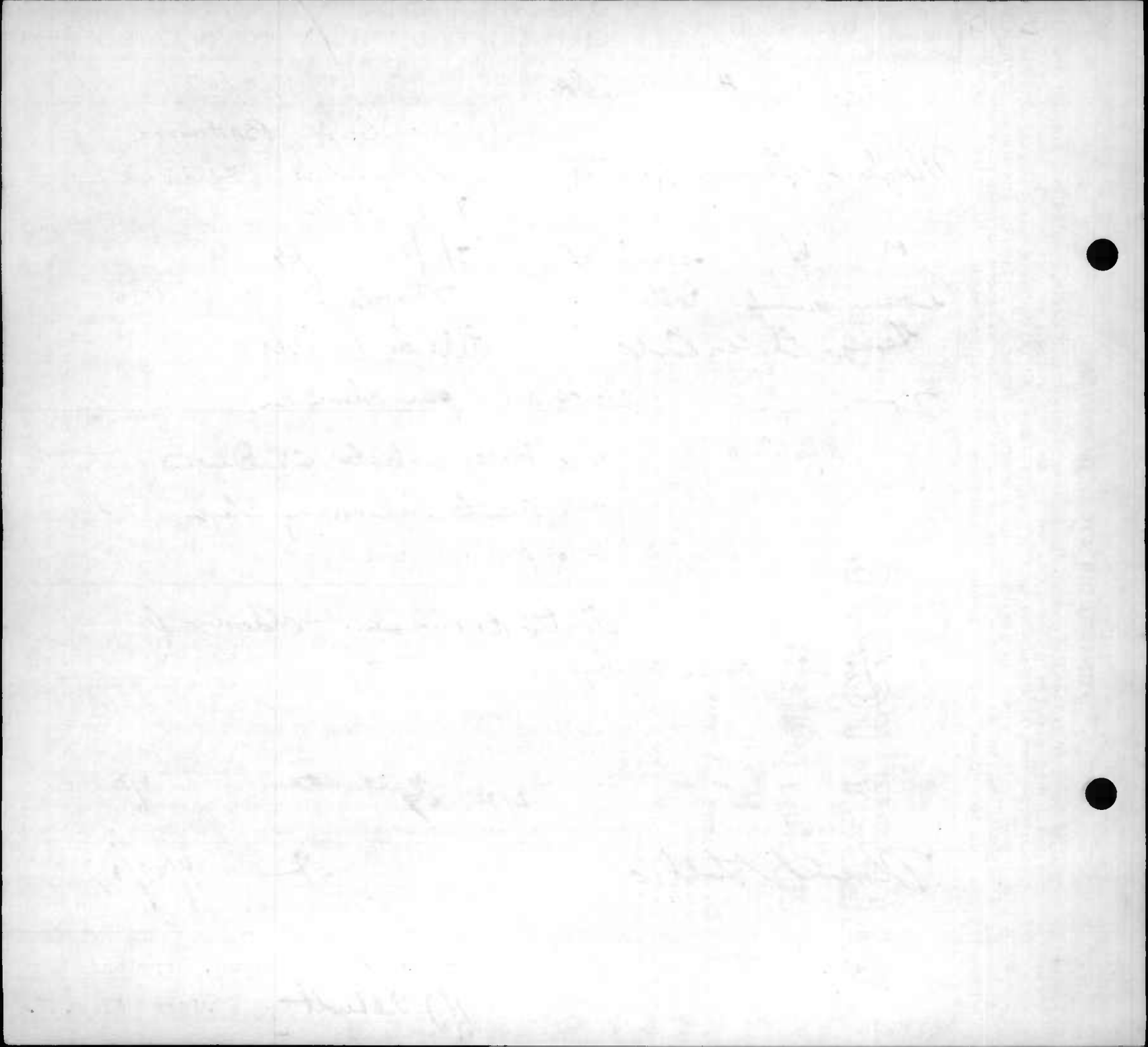
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<i>42 Sinai Hospital</i> | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <i>MARYLAND</i>
B. COUNTY <i>BALTIMORE - MD.</i>
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>25-04</i>
D. STREET ADDRESS (If rural, give location) <i>817 Patapsco Ave.</i> | | | | |
| 5. SEX
<i>m</i> | 6. RACE
<i>w</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
<i>widowed</i> | 8. DATE OF BIRTH
<i>6/19/97</i> | 9. AGE (In years last birthday)
<i>64</i> | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Stationery Engineer</i> | | | 10B. KIND OF BUSINESS OR INDUSTRY
<i>Balto. Transit Co.</i> | | 11. BIRTHPLACE (State or foreign country)
<i>New York</i> | | | 12. CITIZEN OF WHAT COUNTRY?
<i>U. S.</i> | |
| 13. FATHER'S NAME
<i>Henry Fromme</i> | | | | | 14. MOTHER'S MAIDEN NAME
<i>Anna</i> | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>Yes W. W. 1</i> | | | 16. SOCIAL SECURITY NO.
<i>213-10-0441</i> | | 17. INFORMANT ADDRESS
<i>Miss Blanche Fromme 817 Patapsco Ave. (21225)</i> | | | | |
| 18. <i>199.21</i>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
<i>Carcinoma</i> | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | | | | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION
<i>14. 3. 67</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
<i>Abdominal mass - Acute</i> | | 20A. AUTOPSY? (Yes or No)
<i>No</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>5. 1. 19 67</i> to <i>5. 1. 19 67</i> , that (I) (we) last saw the deceased alive on <i>5. 1. 19 67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
<i>R. Theodore</i> | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
<i>5. 1. 67</i> | | |
| 23C. PHYSICIAN'S NAME (Type)
<i>ROGER THEODORE</i> | | | | | 23D. ADDRESS
<i>SINAI HOSPITAL</i> | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 24B. DATE
<i>May 5, 1967</i> | | 24C. NAME of CEMETERY or CREMATORY
<i>Glen Haven Mem. Pk.</i> | | 24D. LOCATION (City, town, or county) (State)
<i>Glen Burnie, Maryland</i> | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<i>MAY 4 1967</i> | | 25B. NAME OF REGISTRAR
<i>Robert E. Farley</i> | | 25C. FUNERAL DIRECTOR ADDRESS
<i>George J. Gonce 4001 Ritchie Hwy. (21225)</i> | | | | | |

FOR THE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|---------------------|---|------------------------------------|--|---|
| BIRTH NO. 67 4380 | | BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | Registered No. 67 4380 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) GORDON H. CADE, SR. | | 2. DATE AND HOUR OF DEATH
4/30/67 11:45 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)
A. STATE Maryland B. COUNTY Baltimore Co | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Hydson 21071 53-00 | |
| FULL NAME OF HOSPITAL OR INSTITUTION
Maryland General Hospital 48 | | (If not in hospital or institution, give street address or location) | | D. STREET ADDRESS (If rural, give location)
9 Fisher | |
| 5. SEX
M | 6. RACE
W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
married | 8. DATE OF BIRTH
3/11/98 | 9. AGE (In years last birthday)
69 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
supermarket assistant | | 10B. KIND OF BUSINESS OR INDUSTRY
Balti County | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
George Elmer Cade | | 14. MOTHER'S MAIDEN NAME
Alberta Barber | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
no | | 16. SOCIAL SECURITY NO.
220-09-7631 | | 17. INFORMANT
prev admin | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
II | | CAUSE OF DEATH
(C) Anterovascular CV Dues
(B) Acute Pulmonary Ede
(A) Pneumonia | | INTERVAL BETWEEN ONSET AND DEATH
2 days | |
| 19A. DATE OF OPERATION
2 3/67 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
aortic aneurysm | | 20A. AUTOPSY? (Yes or No)
yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 4/29 1967 to 4/30 1967 , that (I) (we) last saw the deceased alive on 4/30 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Donald Feldner | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
4/30/67 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS
M.D. Owings Mills, Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
5/3/67 | | 24C. NAME OF CEMETERY or CREMATORY
All Saints Cemetery | |
| 24D. LOCATION (City, town, or county) (State)
Reisterstown, Maryland | | 25A. DATE REC'D BY HEALTH DEPT.
MAY 4 1967 | | 25B. NAME OF REGISTRAR
Robert E. Farber | |
| 25C. FUNERAL DIRECTOR
H. J. Eckhardt | | ADDRESS
Owings Mills, Md. | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

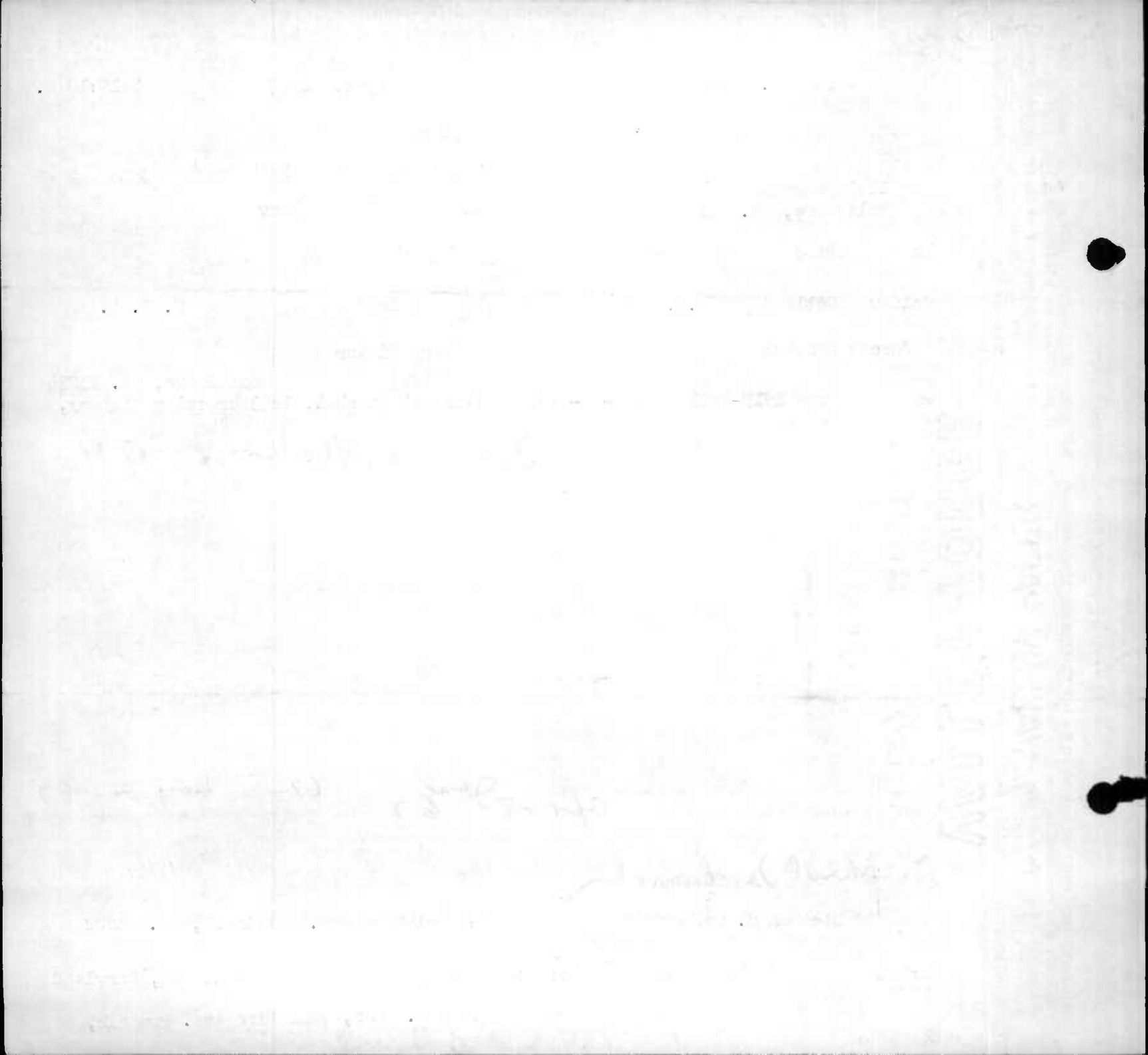
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 4381 | |
|---|--|---|---|--|---|
| BIRTH NO.
67 4381 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO.
1. NAME OF DECEASED
(Type or Print) Joseph J. Duschel | | 2. DATE AND HOUR OF DEATH
May 2, 1967 10:10 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

1243 Broening Highway
Baltimore, Md. 21224 | | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)
A. STATE Maryland
B. COUNTY

C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore 21224
D. STREET ADDRESS (If rural, give location)
1243 Broening Highway | | | |
| 5. SEX
Male | 6. RACE
White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
Married | 8. DATE OF BIRTH
3/4/01 | 9. AGE (In years last birthday)
66 | 10. UNDER 1 Yr. Months Days
11. UNDER 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Molder Retired | | 10B. KIND OF BUSINESS OR INDUSTRY
U.S. Navy Gun Factory | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | | | | | |
| 13. FATHER'S NAME
Joseph Duschel | | | 14. MOTHER'S MAIDEN NAME
Mary Dieter | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
Yes Army 1919-1921 | | 16. SOCIAL SECURITY NO.
212-07-5269 | | 17. INFORMANT
(Wife) Elizabeth Duschel, 1243 Broening Highway, Baltimore, Md. 21224 | |
| CAUSE OF DEATH | | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) DUE TO
Carcinoma of the Pharynx | | INTERVAL BETWEEN ONSET AND DEATH
9 Mo | |
| (B) DUE TO | | (C) DUE TO | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
NO | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan 1967 to May 2 1967 that (I) (we) last saw the deceased alive on Apr 28 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Stephen C. Mackowiak | | | | 23B. DATE SIGNED
5/2/67 | |
| 23C. PHYSICIAN'S NAME (Type)
Stephen C. Mackowiak | | | | 23D. ADDRESS
6714 Holabird Ave. Baltimore, Md. 21222 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
5/5/67 | | 24C. NAME OF CEMETERY or CREMATORY
Gardens of Faith Cemetery | |
| 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 4 1967 | | 25B. NAME OF REGISTRAR
Robert E. Taylor, Md. | | 25C. FUNERAL DIRECTOR ADDRESS
John J. Duda, 7922 Wise Ave. Dundalk, Md | |

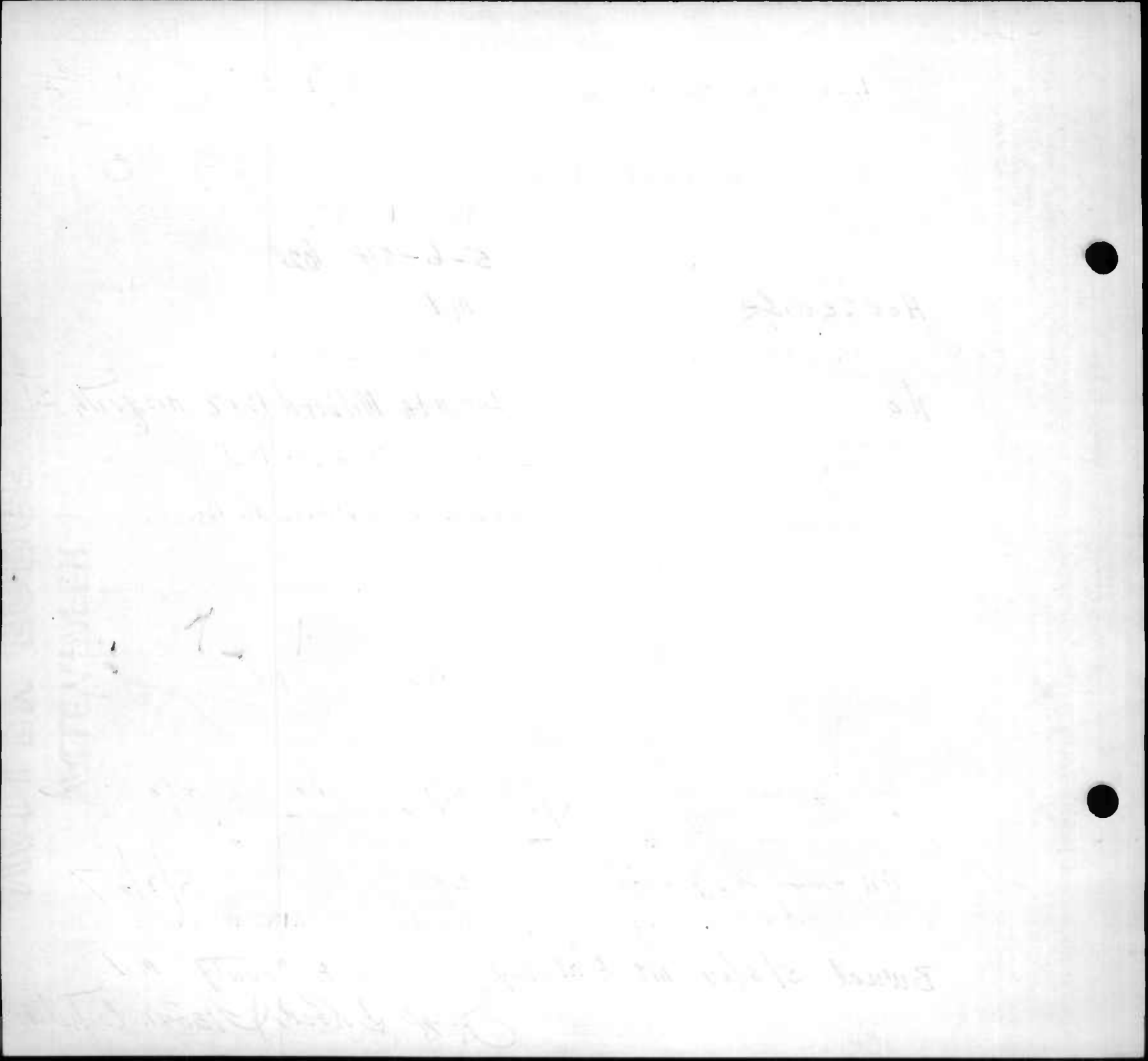


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | | | | |
|---|--|-------------------------|--|--|---|-----------------------------------|--|--|--|--|--|-----------------------------|--|--|
| BIRTH NO. 67 4382 | | | | | CERTIFICATE OF DEATH | | | | | Registered No. 67 4382 | | | | |
| 1. NAME OF DECEASED
(Type or Print) Lucinda Bond | | | | | 2. DATE AND HOUR OF DEATH
5/2/67 1:50 A.M. | | | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
THE JOHNS HOPKINS HOSPITAL
33 | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE MARYLAND
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE
D. STREET ADDRESS (If rural, give location)
1517 AUSQUITH STREET 21202 | | | | | | | | | |
| 5. SEX
FEMALE | | 6. RACE
NEGRO | | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
WIDOWED | | 8. DATE OF BIRTH
5-6-04 | | 9. AGE (In years lost birthday)
62 | | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | | | 11. BIRTHPLACE (State or foreign country)
MD. | | | | |
| 12. CITIZEN OF WHAT COUNTRY? | | | | | 13. FATHER'S NAME
WILLIAM SHORT | | | | | 14. MOTHER'S MAIDEN NAME
NELLIE COLLINS | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | | | 16. SOCIAL SECURITY NO. | | | | | 17. INFORMANT
LUCINDA Milborn 1517 Ausquith St | | | | |
| 18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
420.11
Isolated W. H. Acute MI
DUE TO
Atherosclerotic Cardiovascular Disease
INTERVAL BETWEEN ONSET AND DEATH
51 | | | | | 19. DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION
2 | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20A. AUTOPSY? (Yes or No)
Yes | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)
NO | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (s) (this hospital) attended the deceased from 5/2 1967 to 5/2 1967 , that (s) (we) last saw the deceased alive on 5/2 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (s) (We) (did) (do not) view the body after death. | | | | | | | | | | | | | | |
| 23A. SIGNATURE
Murray A. Katz | | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | | | 23B. DATE SIGNED
5/2/67 | | | | |
| 23C. PHYSICIAN'S NAME (Type)
MURRAY A. KATZ | | | | | M.D. 23D. ADDRESS
THE JOHNS HOPKINS HOSPITAL | | | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | | | | 24B. DATE
5/5/67 | | | | | 24C. NAME of CEMETERY or CREMATORY
MT. CALVARY | | | | |
| 24D. LOCATION (City, town, or county) (State)
A.A. County Md. | | | | | 25A. DATE REC'D BY HEALTH DEPT.
MAY 4 1967 | | | | | 25B. NAME OF REGISTRAR
Robert E. Feltman | | | | |
| 25C. FUNERAL DIRECTOR
Spiegel, Brooks & 1304 N. Central St | | | | | ADDRESS | | | | | | | | | |



48-24-39
FR

1D-162

67 4383

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

67 4383

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

Edward Dobrzykowski (Schultz)

2. DATE AND HOUR OF DEATH

5/3/67

439A

M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

935 Fell Street

21231

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Separated

8. DATE OF BIRTH

1910

9. AGE (In years)

46

lost birthday
49

11. Under 1 Yr.

Months: Days: Hours: Min.

If Under 24 Hrs.

Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

?

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

James Stanislaus Dobrzykowski

14. MOTHER'S MAIDEN NAME

Rose Rosalie Baclawski

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

216-03-0089

17. INFORMANT

ADDRESS

RECORDS: BCM 4940 Eastern Avenue 21224

18. 148X I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Carcinoma of Pharynx

6 mo -

ANTECEDENT CAUSES

(B) DUE TO

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

White At
Work ☐Not White
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12/5 19 66 to 5/3/ 19 67.
that (I) (we) last saw the deceased alive on 5/3 19 67 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

William A. Emerson

M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

5/3/67

23C. PHYSICIAN'S
NAME (Type)

William A Emerson

M.D.

23D. ADDRESS

Baltimore City Hospitals

4940 Eastern Avenue Baltimore, Maryland 21224

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

5/6/67

24C. NAME of CEMETERY or CREMATORIUM

St. Stanislaus Cemetery

24D. LOCATION

(City, town, or county)

Baltimore, Maryland

(State)

25A. DATE REC'D BY HEALTH DEPT.

MAY 4 1967

25B. NAME of REGISTRAR

Robert E. Jenkins

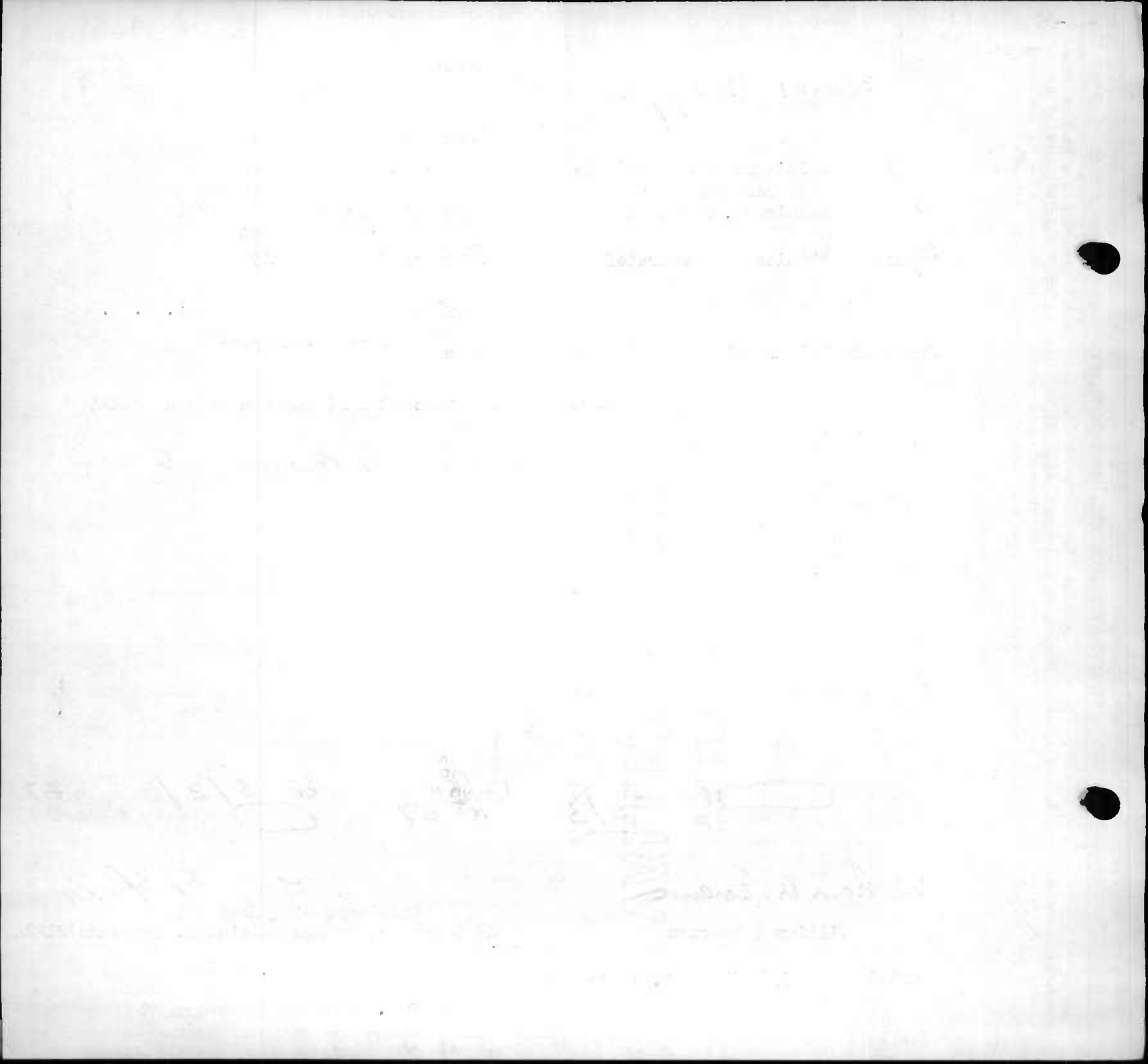
25C. FUNERAL DIRECTOR

George A. Weber 705 South Ann St

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



1
B-516

| BALTIMORE CITY HEALTH DEPARTMENT | | | |
|---|--|--|--|
| BIRTH NO. 67 4384 | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 4384 | |
| M.E. CASE NO. | | | |
| 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR PRONOUNCED DEAD | |
| HILLARD BONAPARTE | | 5-2-67 12:35 PM | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION

2829 WINCHESTER STREET - Amb. Crew #8 | | A. STATE
Maryland | |
| | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore | |
| | | D. STREET ADDRESS (If rural, give location)
2829 Winchester Street | |
| 5. SEX
Male | 6. RACE
Colored | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
WIDOWED | 8. DATE OF BIRTH
6-13-1871 |
| 9. AGE (In years last birthday)
95 | | 10. KIND OF BUSINESS OR INDUSTRY | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
RETIRED | | 11. BIRTHPLACE (State or foreign country)
CALHOUN CO, SOUTH CAROLINA | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
UNK. | |
| 14. MOTHER'S MAIDEN NAME
UNK. | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service) | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Mr. Joseph Bonapart | |
| 18. CAUSE OF DEATH | | ADDRESS
2409 Coldspring | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
Arteriosclerotic cardiovascular disease | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No)
No | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
Werner U. Spitz, M.D. | | DATE SIGNED
5-2-67 | |
| 23A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 23B. DATE
5-6-67 | |
| 23C. NAME OF CEMETERY or CREMATORY
St. John Bapt. Ch. Cem. | | 23D. LOCATION (City, town, or county) (State)
Orangeburg, South Carolina | |
| 24A. DATE REC'D BY HEALTH DEPT.
MAY 4 1967 | | 24B. NAME OF REGISTRAR
Robert E. Spitz | |
| 24C. FUNERAL DIRECTOR
MORTON & DYETT F.H. | | ADDRESS
1701 Laurens | |

Wm. W. W. W.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JESSE FLIGGINS

2. DATE AND HOUR PRONOUNCED DEAD

5-2-67 5:00 PM M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

33 JOHNS HOPKINS HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1831 Bolton Street 21217

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

INFANT

8. DATE OF BIRTH

2-13-1967

9. AGE (In years
last birthday)If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

2½

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

INFANT

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

BALTIMORE, MARYLAND

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

SAMUEL MOSES

14. MOTHER'S MAIDEN NAME

ELVA V. FLIGGINS

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mr. Jesse Fliggins 1831 Bolton St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) Interstitial pneumonitis and otitis media - (SDII)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
m. WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☒

DATE SIGNED

ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

RUSSELL S. FISHER, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

5-3-67

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

5-5-67

23C. NAME OF CEMETERY or CREMATORY

Mount Auburn Cem.

23D. LOCATION

(City, town, or county)

Baltimore,

(State)

Maryland

24A. DATE REC'D BY HEALTH DEPT.

MAY 4

1967

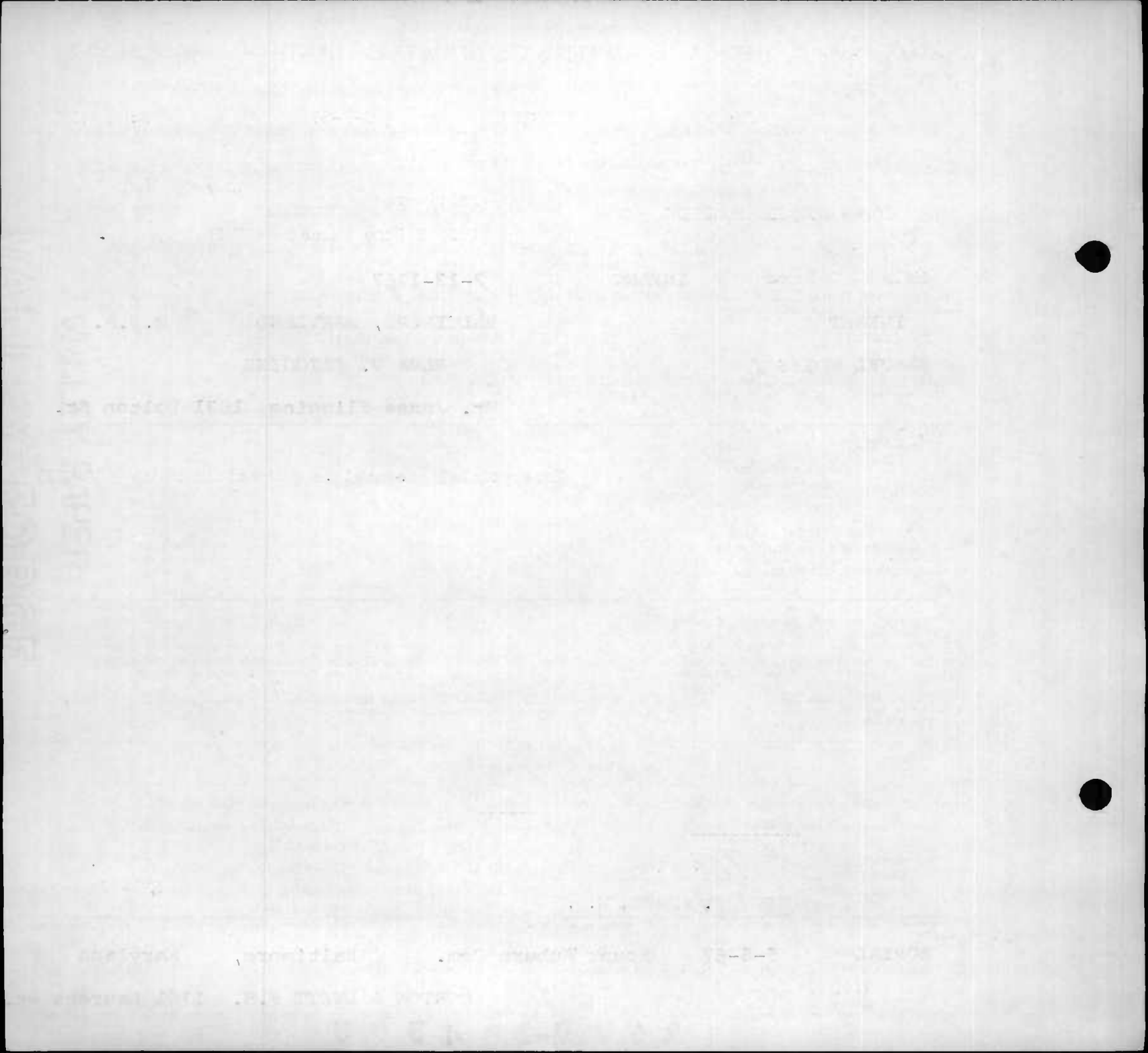
24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

MORTON & DYETT F.H. 1701 Laurens St.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 4386 | |
|---|----------------------------|--|---|--|---|
| BIRTH NO. 67 4386 | | CERTIFICATE OF DEATH | | Registered No. 67 4386 | |
| 1. NAME OF DECEASED
(Type or Print) CANTY, ROXIE LEE | | | 2. DATE AND HOUR OF DEATH
5-3-'67 12-30 P.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Baltimore | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
Lutheran Hospital of Maryland
730 Ashburton Street, Baltimore. | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | | |
| D. STREET ADDRESS (If rural, give location)
2848 W. Mulberry Street | | | E. STREET ADDRESS (If rural, give location) | | |
| 5. SEX
Female | 6. RACE
Coloured | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married | 8. DATE OF BIRTH
9-22-13 | 9. AGE (In years last birthday)
53 years | 10. Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
In Consolidated Engineering | | | 11. BIRTHPLACE (State or foreign country)
Virginia | | |
| 10B. KIND OF BUSINESS OR INDUSTRY | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | |
| 13. FATHER'S NAME
Pledge Chmney | | | 14. MOTHER'S MAIDEN NAME
Ruby Chmney | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO.
224-10-3558 | | |
| 17. INFORMANT
Mr. Musker Canty, Jr. | | | ADDRESS
2848 W. Mulberry | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
570.5 1+260X
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) | | | CAUSE OF DEATH
severe hemorrhage | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (A) DUE TO
Acute Hemorrhagic enteropathy | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Diabetes mellitus Wrenner | | | (B) DUE TO | | |
| 19A. DATE OF OPERATION
4/21/67 | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
Intestinal obstruction | | |
| 20A. AUTOPSY? (Yes or No)
No | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | 21D. TIME OF INJURY (Approx.) | | |
| 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that (I) (this hospital) attended the deceased from 3-27-1967 to 5-3-1967 , that (I) (we) last saw the deceased alive on 5-3-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Anjeshi | | | 23B. DATE SIGNED
5-3-67 | | |
| 23C. PHYSICIAN'S NAME (Type)
ANIL M. JOSHI | | | 23D. ADDRESS
Lutheran Hospital of Maryland | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | | 24B. DATE
5-7-67 | | |
| 24C. NAME of CEMETERY or CREMATORY
Mt Auburn Cem. | | | 24D. LOCATION (City, town, or county) (State)
Balto. Md. | | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 4 1967 | | | 25B. NAME OF REGISTRAR
Morton E Dyett F.H. | | |
| 25C. FUNERAL DIRECTOR
1701 HAWKENS | | | ADDRESS | | |

18 3

Bridge Church

Robert Church
2000 W. 10th St.
Anchorage, Alaska 99501
Phone: 261-1111

1000 W. 10th St.
Anchorage, Alaska 99501

Serial 5-1-60 H. Hansen Co
1000 W. 10th St. Anchorage, Alaska 99501

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 67 4387 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 4387 | |
|---|-------------------------|---|---|--|--|---|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) Yiengst, Susan | | | | 2. DATE AND HOUR OF DEATH
April 30, 1967 11:00 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
38 University Hosp.
Baltimore, Maryland | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE Md B. COUNTY Baltimore
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 6701 Rosemont Ave | | | |
| 5. SEX
F | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
MARRIED | 8. DATE OF BIRTH
28 Apr 1896 | 9. AGE (In years last birthday)
71 | 10. Under 1 Yr. Months: Days: Hours: Min. | | 11. Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | | 10B. KIND OF BUSINESS OR INDUSTRY
- | | 11. BIRTHPLACE (State or foreign country)
Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY?
USA |
| 13. FATHER'S NAME
Levi Bathurst | | | | 14. MOTHER'S MAIDEN NAME
Catherine Miller | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | 16. SOCIAL SECURITY NO.
219-30-6434 | | 17. INFORMANT
Marvin J. Yiengst | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
E 900.01 | | | | CAUSE OF DEATH
(A) DUE TO
Cranio-cerebral trauma
(B) DUE TO
(C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH
4/29/67 | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II | | | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION
29 Apr 67 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
Subdural hematoma | | 20A. AUTOPSY? (Yes or No)
No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input checked="" type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
Home | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
at home 6701 Rosemont Ave | | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
Apr 28 67 8:30 pm | |
| 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR?
Fell down stairs at home. | | 21G. DATE SIGNED
4/30/67 | | 21H. DATE SIGNED | |
| 22. I certify that (I) (this hospital) attended the deceased from 4/29/67 to 4/30 19 67 , that (I) (we) last saw the deceased alive on 4/30 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | 23A. SIGNATURE
Robert S. Holt | | | |
| 23B. PHYSICIAN'S NAME (Type)
Robert S. Holt | | | | 23C. ADDRESS
University Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
5-5-67 | | 24C. NAME of CEMETERY or CREMATORY
Fairview Cemetery | | 24D. LOCATION (City, town, or county) (State)
Altoona, Pa. | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 5 1967 | | 25B. NAME OF REGISTRAR
Robert E. Fairbank | | 25C. FUNERAL DIRECTOR
John C. Miller Inc-6415 Belair Rd.-21206 | | ADDRESS | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 4388 | |
|---|------------------|---|------------------------------|---|---|
| BIRTH NO. 67 4388 | | CERTIFICATE OF DEATH | | 67 4388 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) Charles N. Selvage | | 2. DATE AND HOUR OF DEATH
5/2/67 8:00a M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Baltimore 21206 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | |
| FULL NAME OF HOSPITAL OR INSTITUTION
Johns Hopkins Hospital
33 | | D. STREET ADDRESS (If rural, give location)
3811 Birchview Avenue | | 27-05 | |
| 5. SEX
Male | 6. RACE
white | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
Widow | 8. DATE OF BIRTH
11-17-79 | 9. AGE (in years last birthday)
87 | 10. If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Pipe-Fitter | | 10B. KIND OF BUSINESS OR INDUSTRY
Standard Oil | | 11. BIRTHPLACE (State or foreign country)
Balto. Md. | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
Charles | | 14. MOTHER'S MAIDEN NAME
Mary E. Schisler | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
214-01-4254 | | 17. INFORMANT
Claude N. Selvage-3720 Gibbons Ave | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
CAUSE OF DEATH
(A) Cardiac arrest
(B) Respiratory arrest
(C) COPD, possible MI. | | INTERVAL BETWEEN ONSET AND DEATH
minutes
on 5/1 | | | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
no | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from 4/30 1967 to 5/2 1967, that (I) (we) last saw the deceased alive on 5/2 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | 23A. SIGNATURE
Terry Ersel Gagon M.D. | |
| 23B. DATE SIGNED
5/2/67 | | 23C. PHYSICIAN'S NAME (Type)
Terry Ersel Gagon | | 23D. ADDRESS
The Johns Hopkins Hospital | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
5-5-67 | | 24C. NAME OF CEMETERY or CREMATORY
Baltimore Cemetery | |
| 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | | 25A. DATE REC'D BY HEALTH DEPT.
MAY 5 1967 | | 25B. NAME OF REGISTRAR
John C. Miller Inc-415 Belair Rd.-21206 | |
| 25C. FUNERAL DIRECTOR
John C. Miller Inc-415 Belair Rd.-21206 | | 25D. ADDRESS | | | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | Registered No. 67 4389 | |
|--|---------------------------|---|--|---|--|---|--|------------------------------------|--|------------------------|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| BIRTH NO.
67 4389 | | M.E. CASE NO. | | | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) <i>Crandle, Esther</i> | | | | | | 2. DATE AND HOUR OF DEATH
<i>4/29/67 8²⁰ A.M.</i> | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE MARYLAND
B. COUNTY BALTIMORE
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE
D. STREET ADDRESS (If rural, give location)
201 N. AISQUITH ST. | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
33 THE JOHNS HOPKINS HOSPITAL | | | | | | | | | | | |
| 5. SEX
FEMALE | 6. RACE
NEGROID | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
SINGLE | | 8. DATE OF BIRTH
<i>Feb. 3, 1911</i> | 9. AGE (In years last birthday)
<i>56</i> | If Under 1 Yr. Months: Days: Hours: Min. | | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>House wife</i> | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<i>Augusta, Ga.</i> | | 12. CITIZEN OF WHAT COUNTRY? | | | |
| 13. FATHER'S NAME
<i>Willie Mathis</i> | | | | 14. MOTHER'S MAIDEN NAME
<i>Eugene Walton</i> | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
<i>Dents Funeral Home Augusta Ga.</i> | | | | | |
| 18. 272 XI
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
CAUSE OF DEATH
(A) <i>Hypopituitarism</i>
DUE TO
(B) <i>Pituitary adenoma</i>
DUE TO
(C)
INTERVAL BETWEEN ONSET AND DEATH
<i>~ 6 mos</i>
<i>~ 25 yrs</i> | | | | | | | | | | | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | | | | | |
| 20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
II
<i>Possible pulmonary emboli</i> | | | | | | <i>24 hour</i> | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<i>Yes</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
<i>No</i> | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (1) (this hospital) attended the deceased from <i>4/15/67</i> to <i>4/29/67</i> that (1) (we) last saw the deceased alive on <i>4/29/67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE
<i>Sherrard L. Hayes</i> | | | | | | M.D. <input type="checkbox"/> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
<i>4/29/67</i> | | | |
| 23C. PHYSICIAN'S NAME (Type)
SHERRARD L. HAYES | | | | | | 23D. ADDRESS
THE JOHNS HOPKINS HOSPITAL | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Removal</i> | | 24B. DATE
<i>5/2/67</i> | | 24C. NAME OF CEMETERY or CREMATORY
<i>Cedar Grove</i> | | 24D. LOCATION (City, town, or county) (State)
<i>Augusta Ga</i> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 5 1967 | | 25B. NAME OF REGISTRAR
<i>R. E. E. Taylor</i> | | 25C. FUNERAL DIRECTOR
<i>Dents Funeral Home</i> | | ADDRESS
<i>Augusta Ga</i> | | | | | |

1. *Augin* -

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | | | | | |
|--|--|-----------|--|--|--|--------------------------|--|--|--|--|--|-------------------------------------|--|--|--|
| BIRTH NO. 67 4390 | | | | | CERTIFICATE OF DEATH | | | | | Registered No. 67 4390 | | | | | |
| M.E. CASE NO. | | | | | 1. NAME OF DECEASED (Type or Print) Edward John E. Welsh | | | | | 2. DATE AND HOUR OF DEATH May 1, 1967 1:00 P.M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | | | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | | A. STATE Maryland | | | | | B. COUNTY | | | | | |
| Maryland General Hospital | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | | | 8-01 | | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location) 2822 Lake Ave | | | | | | | | | | |
| 5. SEX M | | 6. RACE W | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married | | 8. DATE OF BIRTH 11/1/98 | | 9. AGE (In years last birthday) 68 | | If Under 1 Yr. Months: Days: | | If Under 24 Hrs. Hours: Min. | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician | | | | 10B. KIND OF BUSINESS OR INDUSTRY U.S. Fed. Gov't. | | | | 11. BIRTHPLACE (State or foreign country) Wash. D.C. | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME William Welsh | | | | | 14. MOTHER'S MAIDEN NAME Mary X X X X Sullivan | | | | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | | | | 16. SOCIAL SECURITY NO. 215-09-4608 | | | | | 17. INFORMANT (nee Yarchel) Cecelia M. Welsh (wife) ADDRESS same | | | | | |
| 18. 177X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | CAUSE OF DEATH (A) Carcinoma Prostate (B) metastases (C) | | | | | INTERVAL BETWEEN ONSET AND DEATH 1 1/2 yrs | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | | | | | |
| 19A. DATE OF OPERATION | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20A. AUTOPSY? (Yes or No) No | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from January 21 1967 to May 1 1967, that (I) (we) last saw the deceased alive on May 1 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | | | | | |
| 23A. SIGNATURE W. Michael Gould | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | | 23B. DATE SIGNED 5/1/67 | | | | | |
| 23C. PHYSICIAN'S NAME (Type) W. MICHAEL GOULD | | | | | 23D. ADDRESS M.D. | | | | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | | | 24B. DATE 5/5/67 | | | | | 24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cemetery | | | | | |
| | | | | | | | | | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAY 5 1967 | | | | | 25B. NAME OF REGISTRAR Robert E. Szabo | | | | | 25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane | | | | | |

John E. Welch

Maryland

Baltimore

5505 Lake Ave

Maryland General Hospital

11/17 42

March

W

M

U.S.A.

U.S. Post Office - Baltimore, Md.

Post Office - Baltimore, Md.

Post Office - Baltimore, Md.

General Post Office
(Baltimore)

312-88-4888

Carroll County
Baltimore, Md.

No.

January 21 42

Post

W. R. Welch

21/1/42

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. | |
|---|--|--|--|--|--|
| 67 4391 | | | | 67 4391 | |
| CERTIFICATE OF DEATH | | | | | |
| BIRTH NO.
M.E. CASE NO. | | 2. DATE AND HOUR OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) | | 5/2/67 3:45 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | A. STATE B. COUNTY | | | |
| 44 Union Memorial Hospital | | Maryland Baltimore City | | | |
| 5. SEX | | 6. RACE | | 7. (MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)) | |
| M Caucasian | | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 8. DATE OF BIRTH | |
| Supervisor | | Chevrolet Plant | | 3/30/15 52 | |
| 13. FATHER'S NAME | | 14. MOTHER'S MARDEN NAME | | 9. AGE (In years lost birthday) | |
| John Szymaniak | | Christina Wentland | | 52 | |
| 15. Was Deceased Ever in U. S. Armed Forces (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 12. CITIZEN OF WHAT COUNTRY? | |
| no | | | | USA | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| 763X I | | Carcinoma of Lung with Metastasis | | | |
| ANTECEDENT CAUSES | | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| NO | | | | NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 4/20/1967 to 5/2/1967, that (I) (we) last saw the deceased alive on 5/2/1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| Charles H. Classen, Jr. | | | | 5/2/67 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| CHARLES H. CLASSEN, JR., M.D. | | | | THE UNION MEMORIAL HOSPITAL | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 5/5/67 | | St. Stanislaus Cemetery | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| MAY 5 1967 | | Robert E. Tarkenton | | Schimunek Funeral Home, Inc. | |
| | | | | 3331 Brehms Lane | |

John Josephine 28 years old

born in Baltimore City

Union Memorial Hospital 8320 Holbrook Road

M. Cancer 3/30/12 22

supervisor Maryland USA

John 28 years old Christian Maryland

Mrs Josephine 28 years old

Consistent of lung with

metastasis

no

no

2/12/12 22

2/12

0

0

Charles McManis

X

2/12/12

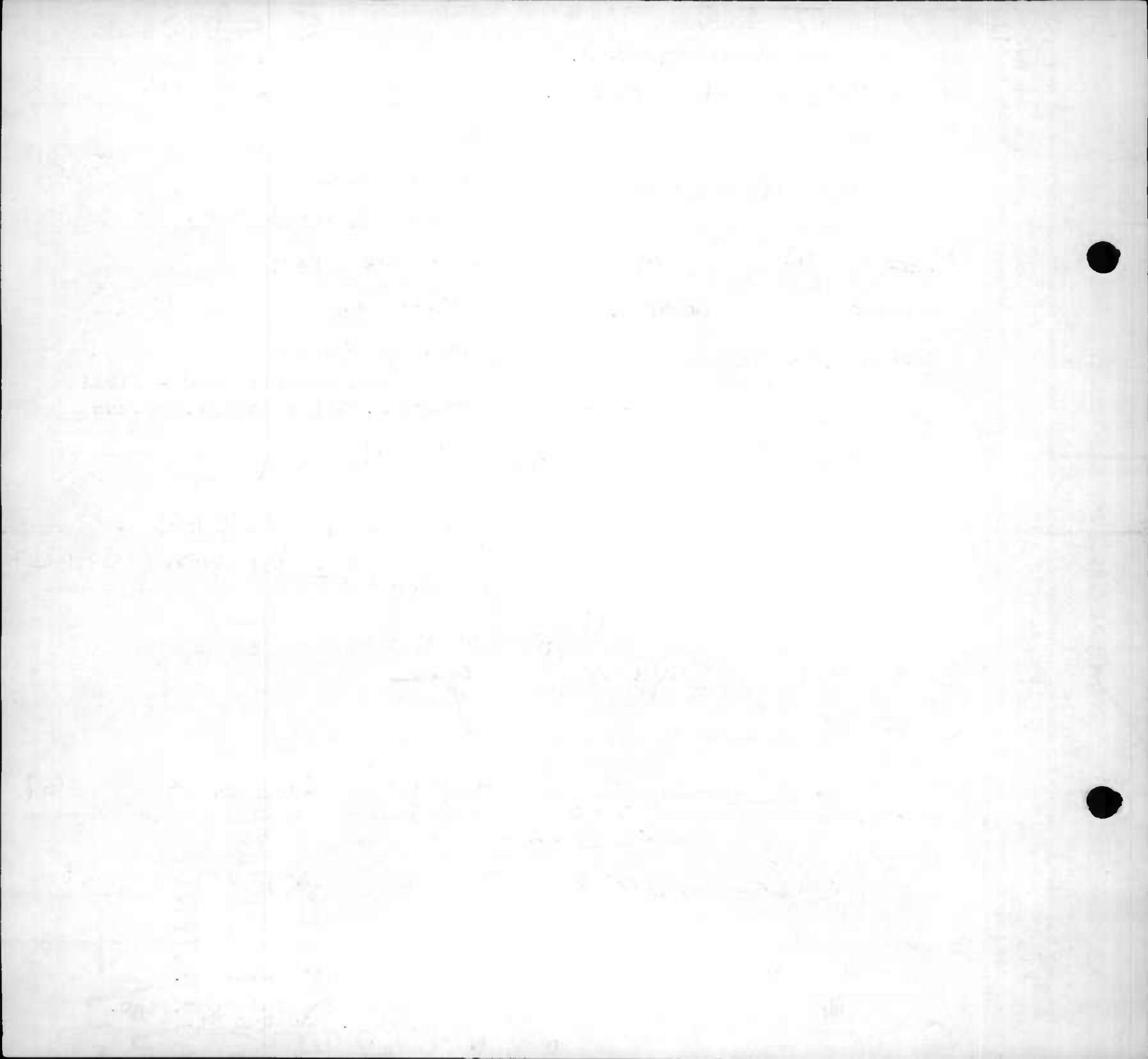
CHARLES W. McMANIS

THE UNION MEMORIAL HOSPITAL

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 4392 | |
|--|--|---|--|--|--|
| 67 4392 | | | | CERTIFICATE OF DEATH | |
| BIRTH NO. | | M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) | |
| | | | | XXXXXX XXXXXXXX Bernard J. Stierstorfer | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 2. DATE AND HOUR OF DEATH | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
38 University Hospital | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY Baltimore | | | |
| 5. SEX M | | 6. RACE W | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) M | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Printer | | 10B. KIND OF BUSINESS OR INDUSTRY
Oscar T. Smith Co | | 9. AGE (In years last birthday) 64 | |
| 13. FATHER'S NAME
John Stierstorfer | | 14. MOTHER'S MAIDEN NAME
Mary Hoffman | | 11. BIRTHPLACE (State or foreign country)
Baltimore Maryland | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
212-05-9947 | | 12. CITIZEN OF WHAT COUNTRY?
U.S. | |
| 17. INFORMANT
Bernard J. Stierstorfer, son, abn | | ADDRESS
155 Bennett Road - 21221 | | | |
| 18. 43001 | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) Renal Insufficiency | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) ASCD & Abdominal Aneurysm | | | |
| | | (C) Arteriosclerosis by-pass 5-1-67 GRAFT. | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | Hypertension | | | |
| 19A. DATE OF OPERATION
5-1-67 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
ASCD. | | 20A. AUTOPSY? (Yes or No) yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that the (this hospital) attended the deceased from 4-19 19 67 to 5-3 19 67 , that he (we) lost saw the deceased alive on 5-3 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. He (We) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
[Signature] | | M.D. <input type="checkbox"/> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
5-3-67 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS
M.D. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
5/6/67 | | 24C. NAME OF CEMETERY or CREMATORY
Baltimore Cemetery | |
| | | | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 5 1967 | | 25B. NAME OF REGISTRAR
Robert E. Jackson | | 25C. FUNERAL DIRECTOR
Schimunek Funeral Home, Inc. | |
| | | | | ADDRESS
2601 E. Madison St. | |



FUNERAL DIRECTOR: IMPORTANT

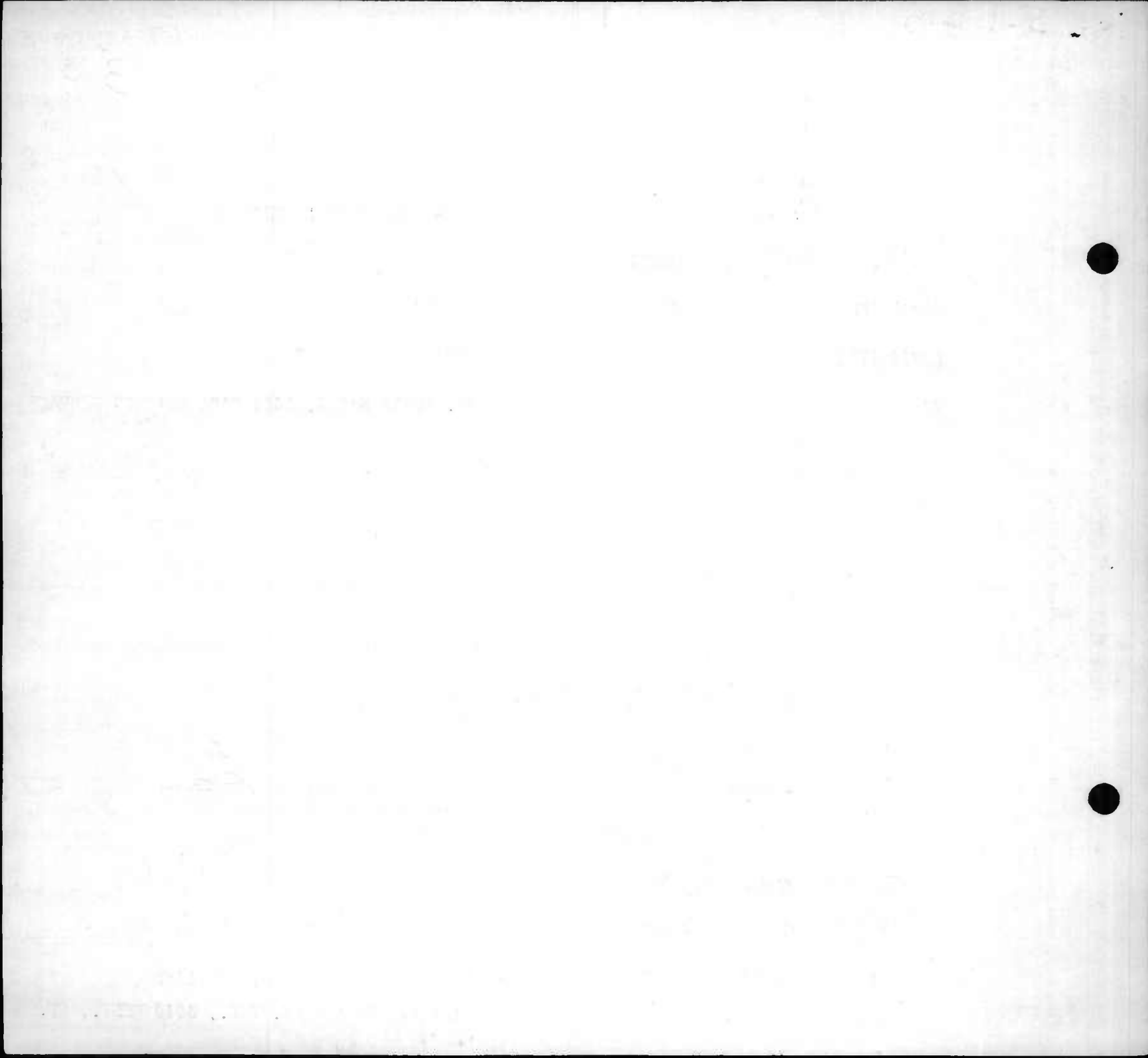
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 4388 | |
|---|--|---|--|---|---|
| BIRTH NO.
67 4388 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO.
1. NAME OF DECEASED
(Type or Print) Mary Sachs | | 2. DATE AND HOUR OF DEATH
May 2, 1967 3 P. M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
90 Friedlers Nursing Home
2449 Shirley Avenue | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY _____
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE
D. STREET ADDRESS (If rural, give location)
2625 PARK HEIGHTS TERRACE #15 | | | |
| 5. SEX
Female | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
WIDOWED | 8. DATE OF BIRTH | 9. AGE (In years last birthday)
87 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWIFE |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY
AT HOME | | 11. BIRTHPLACE (State or foreign country)
RUSSIA | 12. CITIZEN OF WHAT COUNTRY?
USA |
| 13. FATHER'S NAME
LOUIS STARK | | | 14. MOTHER'S MAIDEN NAME
ETTA ? | | |
| 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
UNKNOWN | | 17. INFORMANT
MR. MEYER SACHS, 2625 PARK HEIGHTS TERRACE #15 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) Acute myocardial infarction
DUE TO
(B) Arteriosclerotic cardiovascular disease
DUE TO
(C) _____

INTERVAL BETWEEN ONSET AND DEATH
5 minutes
Several years | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from May 1 19 67 to May 2 19 67 that (I) (we) last saw the deceased alive on May 1 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Seymour Rubin M.D. | | | | 23B. DATE SIGNED
5/2/67 | |
| 23C. PHYSICIAN'S NAME (Type)
SEYMOUR RUBIN | | | | 23D. ADDRESS
5415 Park Heights Avenue | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
5/3/67 | | 24C. NAME OF CEMETERY or CREMATORY
AGUDAS ACHIM ANSHE SEARD | |
| 24D. LOCATION (City, town, or county) (State)
ROSEDALE, MARYLAND | | 25A. DATE REC'D BY HEALTH DEPT.
MAY 5 1967 | | | |
| 25B. NAME OF REGISTRAR
G. E. Farley | | 25C. FUNERAL DIRECTOR
SOL LEVINSON & BROS. INC., 6010 REBT., RD. | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

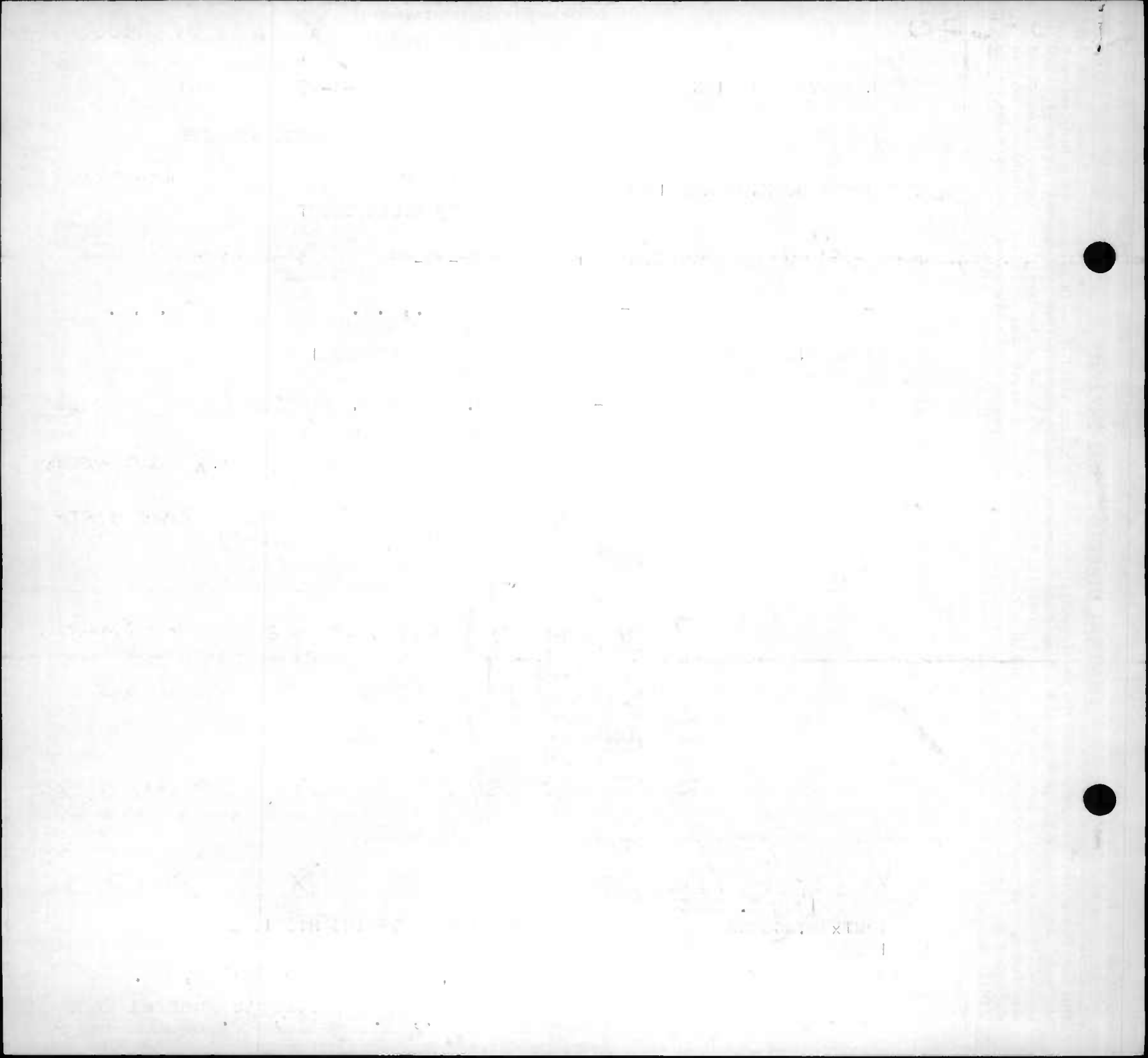
| | | | | | |
|--|----------------------|--|------------------------------|---|---|
| BIRTH NO. 67 4394 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 4394 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) | | LLOYD E. STRAYER, ROY ELLSWORTH | | 2. DATE AND HOUR OF DEATH
MAY 3, 1967 4:40AM M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location) | | A. STATE
MD. | | B. COUNTY
BALTO Co | |
| ST. AGNES HOSPITAL 5-9-67
WILKENS & CATON AVES.
BALTO. 29, MD. | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE #28 | | D. STREET ADDRESS (If rural, give location)
106 MILLER AVE. | |
| 5. SEX
MALE | 6. RACE
CAUCASION | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
DIVORCED | 8. DATE OF BIRTH
12-16-95 | 9. AGE (In years last birthday)
71 | 10. Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
RETIRED-INSPECTOR | | 10B. KIND OF BUSINESS OR INDUSTRY
PENN. RAILROAD | | 11. BIRTHPLACE (State or foreign country)
PENNSYLVANIA | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S. A. | | 13. FATHER'S NAME
EDWARD STRAYER DEC'D | | 14. MOTHER'S MAIDEN NAME
CLARA RHODE DEC'D | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
YES WORLD WAR I | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
ST. AGNES RECORDS: WILKENS & CATON AVES | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) DUE TO
Bronchogenic carcinoma
of the lung with
metastasis to spine,
ribs, liver -
(B) DUE TO
(C) | | INTERVAL BETWEEN ONSET AND DEATH | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from APRIL 21 19 67 to MAY 3 19 67, that (I) (we) last saw the deceased alive on MAY 3 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
R. MARIN | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
5/3/67 | |
| 23C. PHYSICIAN'S NAME (Type)
R. MARIN | | 23D. ADDRESS
M.D. CATON & WILKENS AVE. BALTO MD | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
5/5/67 | | 24C. NAME OF CEMETERY or CREMATORY
Woodlawn | |
| 24D. LOCATION (City, town, or county) (State)
Woodlawn Maryland | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 5 1967 | | 25B. NAME OF REGISTRAR
R. E. Johnson | | 25C. FUNERAL DIRECTOR
J. T. Stansbury 6411 Windsor Mill Rd.
Stansbury & Sons Funeral Home | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 4395 | |
|---|--|--|--|---|---|
| BIRTH NO. 67 4395 | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED
(Type or Print) KATHRYN WASHICK | | | 2. DATE AND HOUR OF DEATH
5-1-67 9AM | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
THE JOHNS HOPKINS HOSPITAL | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND B. COUNTY PRINCE GEORGES
C. CITY OR TOWN (If outside city limits, write RURAL and give township) CHILLUM
D. STREET ADDRESS (If rural, give location) 66-00 6003 BELLE COURT | | |
| 5. SEX
F | 6. RACE
W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
NEVER MARRIED | 8. DATE OF BIRTH
10-14-55 | 9. AGE (In years last birthday)
11 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
- | | 10B. KIND OF BUSINESS OR INDUSTRY
- | 11. BIRTHPLACE (State or foreign country)
Wash., D.C. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. |
| 13. FATHER'S NAME
PETER WASHICK | | | 14. MOTHER'S MAIDEN NAME
DORA FERADOSI | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
- | 17. INFORMANT ADDRESS
Mr. Peter J. Washick (above address) | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)
SUBACUTE BACTERIAL ENDOCARDITIS | | | INTERVAL BETWEEN ONSET AND DEATH
6 1/2 WEEKS | | |
| 19A. DATE OF OPERATION
8/5/66, 11/9/66 | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
TETROLOGY OF FALLOT | | |
| 20A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | | 20B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
<input type="checkbox"/> | | |
| 21A. TIME OF INJURY (Month) (Day) (Year) (Hour)
(APPROX.) | | | 21B. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | |
| 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | | | 21D. HOW DID INJURY OCCUR? | | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/18 19 67 to 5/1 19 67 , that (I) (we) lost saw the deceased alive on 5/1 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Irvin R. Cohen | | | | 23B. DATE SIGNED
5/1/67 | |
| 23C. PHYSICIAN'S NAME (Type)
IRVIN R. COHEN | | | | 23D. ADDRESS
JOHNS HOPKINS HOSPITAL | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | 24B. DATE
5/4/67 | 24C. NAME OF CEMETERY or CREMATORY
Gate of Heaven Cem. | 24D. LOCATION (City, town, or county) (State)
Silver Spring, Md. | | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 5 1967 | 25B. NAME OF REGISTRAR
E. J. ... | 25C. FUNERAL DIRECTOR ADDRESS
Nalley's Funeral Home Inc., Mt. Rainier, Md. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 4396 | |
|--|--|--|---|---|--|
| <div style="display: flex; justify-content: space-between;"> BIRTH NO. 67 4396 CERTIFICATE OF DEATH 5/2/67 </div> | | | | | |
| 1. NAME OF DECEASED
(Type or Print) Maggie B. Neal | | | 2. DATE AND HOUR OF DEATH
4/2/67 4:45 a. m. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
90 Ashburton House | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY _____

C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore.
D. STREET ADDRESS (If rural, give location)
3429 Hickory Ave. | | |
| 5. SEX
fe. | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
widow | 8. DATE OF BIRTH
Nov. 18, 1873 | 9. AGE (In years last birthday)
93 | If Under 1 Yr. Months: _____ Days: _____
If Under 24 Hrs. Hours: _____ Min: _____ |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Va. |
| 12. CITIZEN OF WHAT COUNTRY? | | | 13. FATHER'S NAME
? | | |
| 14. MOTHER'S MAIDEN NAME
? | | | 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)
no | | |
| 16. SOCIAL SECURITY NO.
none | | | 17. INFORMANT ADDRESS
Arthur R. Neal 3908 Hayward Ave. | | |
| 18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
332 X I Cerebral Thrombosis
(A) DUE TO _____

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
(B) DUE TO _____
(C) _____ | | | | | INTERVAL BETWEEN ONSET AND DEATH
2 weeks |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
NO | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from May 9 1962 to May 2 1967, that (I) (we) last saw the deceased alive on Apr. 28 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Abraham B. Hurwitz M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | | 23B. DATE SIGNED
May 4, 1967 | |
| 23C. PHYSICIAN'S NAME (Type)
ABRAHAM B. HURWITZ | | | | 23D. ADDRESS
7501 Liberty Road, Baltimore Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
5/5/67 | | 24C. NAME of CEMETERY or CREMATORY
Lorraine Park | |
| 24D. LOCATION (City, town, or county) (State)
Baltimore | | 25A. DATE REC'D BY HEALTH DEPT.
MAY 5 1967 | | | |
| 25B. NAME OF REGISTRAR
Paul E. Chenoweth Jr. | | 25C. FUNERAL DIRECTOR ADDRESS
Paul E. Chenoweth Jr. 3617 Chestnut Ave. | | | |

to the ...

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 4397

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JOHN C. HUDSON

2. DATE AND HOUR PRONOUNCED DEAD

5-2-67

2:07 PM

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

CERTIFICATE AMENDED
 FULL NAME OF (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
 5-12-67
 CHURCH HOME AND HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

115 N. Milton Avenue 21224

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Nov. 15, 1908

9. AGE (In years
lost birthday)

58-58

If Under 1 Yr. If Under 24 Hrs.
Months, Days, Hours, Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Vendor

10B. KIND OF BUSINESS OR INDUSTRY

Stadium

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

?

14. MOTHER'S MAIDEN NAME

?

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give year or dates of service)

Yes

W.W.11

16. SOCIAL
SECURITY NO.

213-10-0994

17. INFORMANT

John Hudson Jr. 833E. 33rd.

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

422.14002.1
 DISEASE OR CONDITION DIRECTLY
 LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
 heart failure, asthenia, etc. It means the disease,
 injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease
DUE TOII
ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
 RISE TO THE ABOVE CAUSE (A) STATING THE
 UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
 TO THE DEATH BUT NOT RELATED TO THE
 DISEASE OR CONDITION CAUSING IT.

Moderately advanced, old and active pulmonary Tuberculosis

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE

EXAMINER'S

NAME (Type) RUSSELL S. FISHER, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

5-3-67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

5/5/67

23C. NAME OF CEMETERY or CREMATORY

National

23D. LOCATION

(City, town, or county)

Balto.

(State)

24A. DATE REC'D BY HEALTH DEPT.

MAY 5 1967

24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

Paul E. Chenoweth Jr. 3617 Chestnut Ave

ADDRESS

Letter from M.E.'s office

5-12-67

M.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|-------------------------|---|------------------------------------|--|---|
| 1. NAME OF DECEASED
(Type or Print)
Frances Gallagher-Cain | | 2. DATE AND HOUR OF DEATH
5/1/67 5:30 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Baltimore City Hospitals
4940 Eastern Ave.
Baltimore, Maryland # 21224 | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
2011 Jefferson St.
21205 | | | |
| 5. SEX
Female | 6. RACE
White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
Divorced | 8. DATE OF BIRTH
6-26-08 | 9. AGE (In years last birthday)
58 | 10. CITIZEN OF WHAT COUNTRY?
U. S. A. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
New York | |
| 13. FATHER'S NAME
Michael | | 14. MOTHER'S MAIDEN NAME
Mary ? | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
213-03-2663 | |
| 16. SOCIAL SECURITY NO.
213-03-2663 | | 17. INFORMANT
BCH: Records 4940 Eastern Ave. Baltimore, Md. | | ADDRESS #21224 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
CVA | | CAUSE OF DEATH
(A) DUE TO
CVA
(B) DUE TO
Giant Cell Arteritis
(C) _____ | | INTERVAL BETWEEN ONSET AND DEATH
7mo.
9mo. | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
YES | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 9/26 19 66 to 5/1/1 19 67 .
that (I) (we) last saw the deceased alive on 5/1 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
William A. Emerson | | | | 23B. DATE SIGNED
5/1/67 | |
| 23C. PHYSICIAN'S NAME (Type)
William A. Emerson | | | | 23D. ADDRESS
Baltimore City Hospitals
4940 Eastern Ave. Baltimore, Md. # 21224 | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
5/5/67 | | 24C. NAME of CEMETERY or CREMATORY
New Cathedral | |
| 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | | 25A. DATE REC'D BY HEALTH DEPT.
MAY 5 1967 | | | |
| 25B. NAME OF REGISTRAR
Robert E. Fink | | 25C. FUNERAL DIRECTOR
Raymond C. Fink | | | |
| ADDRESS
426 Crain Hwy | | | | | |

2/12

2/12

From: [illegible]

2-26-08

F. W.

the

CVA

and

Great Cell Activities

2/11

2/11

2/11

2/11

2/11

William A. Brown

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|---|---|--|--|--|
| BIRTH NO. 67 4399 | | BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | Registered No. 67 4399 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) Robert E. Poole | | 2. DATE AND HOUR OF DEATH
May - 4th - 67 5.30 A. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE Maryland
B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
Church Home & Hospital | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | | D. STREET ADDRESS (If rural, give location)
2926 O'Donnell St. | |
| 5. SEX
Male | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married | 8. DATE OF BIRTH
7-12-16 | 9. AGE (In years last birthday)
50 | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Tractor - Driver | | 10B. KIND OF BUSINESS OR INDUSTRY
City of Balto. | | 11. BIRTHPLACE (State or foreign country)
Georgia | |
| 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 13. FATHER'S NAME
Grass Cutting - Patterson Park William Poole | | 14. MOTHER'S MAIDEN NAME
Leila Mc Carthur | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
220-14-3019 | | 17. INFORMANT (Wife)
Mrs. Helen Poole, 2926 O'Donnell St. Balto. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Cerebral Hypoxia secondary to Cardiac arrest. | | CAUSE OF DEATH
(A) DUE TO
Carcinoma of Stomach
(B) DUE TO
Pulmonary Embolism
(C) | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION
May - 1st - 67 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
Gastric tumor | | 20A. AUTOPSY? (Yes or No)
YES - | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from April - 16 19 67 to May 4th 19 67 , that (I) (we) last saw the deceased alive on May 4th 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Mervin L. Trair | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
5/4/67 | |
| 23C. PHYSICIAN'S NAME (Type)
MERVIN L. TRAIR | | 23D. ADDRESS
M.D. Church Home & Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
5/8/67 | | 24C. NAME OF CEMETERY or CREMATORY
Gardens of Faith Cemetery | |
| 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 5 1967 | | 25B. NAME OF REGISTRAR
Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR ADDRESS
John J. Duda, 2829 Hudson St. Balto. Md. | |

Church House - 1st St. & O'Donnell St

Male White married. 7-12-16 20

Tractor - Driver City of Bath Georgia

Carriage of stomach
deposited in stomach
except hypoxia section

Wed. 1st 23 gastric tumor

Head of 40
Cupric - 1st
25 2nd 4th

There is a
tumor in stomach
2nd 4th

S-363

67 4400

BALTIMORE CITY HEALTH DEPARTMENT

67 4400

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ROSS

STREETER

2. DATE AND HOUR PRONOUNCED DEAD

April 26, 1967

11:00 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1932 Madison Avenue

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

SEPARATED

8. DATE OF BIRTH

5-1-06

9. AGE (In years
last birthday)

60

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

LABORER

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

S. CAROLINA

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

18.

422.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE

Charles S. Petty

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4/27/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

5-2-67

23C. NAME of CEMETERY or CREMATORY

Mt. Auburn Cem.

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Westport, Md.

24A. DATE RECEIVED BY HEALTH DEPT.

MAY 5 1967

24B. NAME OF REGISTRAR

Robert E. Taylor

24C. FUNERAL DIRECTOR

Caprice V. Cooper

Joseph L. Russ 2202 W. North

2-1-26

1926

1926

2-1-26

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 4401 | |
|---|-------------------------|---|--|--|---|
| BIRTH NO. 67 4401 | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) GREEN, Alice | | 2. DATE AND HOUR OF DEATH
5/3/67 5:15 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Lincoln Memorial Nursing Home
27 N. CAREY ST.
BALTO. MD. 21223 | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE MARYLAND
B. COUNTY BALTIMORE
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE
D. STREET ADDRESS (If rural, give location)
2638 E. OLIVER ST. | | |
| 5. SEX
F | 6. RACE
Negro | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
WIDOWED | 8. DATE OF BIRTH
1/19/81 | 9. AGE (In years lost birthday)
86 | If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Tailor | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
VA | |
| 13. FATHER'S NAME
Sam Minor | | | 14. MOTHER'S MAIDEN NAME
Eveline | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
no | | 16. SOCIAL SECURITY NO.
219-30-8696 | | 17. INFORMANT
Herbert Minor | |
| 18. 332 X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Cerebral Thrombosis
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | ADDRESS
same
INTERVAL BETWEEN ONSET AND DEATH | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from April 26 1967 to May 3 1967 , that (I) (we) last saw the deceased alive on May 3 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Annis Tennarine M.D. | | | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type)
Annis Tennarine M.D. | | | | 23D. ADDRESS
930 W. TENDRICK ST | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
5-6-67 | | 24C. NAME OF CEMETERY or CREMATORY
Cath | |
| 24D. LOCATION (City, town, or county) (State)
Balto. Md. | | 25A. DATE REC'D BY HEALTH DEPT.
MAY 5 1967 | | | |
| 25B. NAME OF REGISTRAR
Robert E. Farkas | | 25C. FUNERAL DIRECTOR
Henry B. Wilson 1000 Brantley Ave. | | | |

Office of the

Inspector

Room 101

2028 S. Green St.

1/19/81 80

1/24

1044th. 104. 21223
27th. 27th. 27th.

F. Notes

1044th. 104. 21223

Central Chamberlain

1044th. 104. 21223

1044th. 104. 21223

1044th. 104. 21223

1044th. 104. 21223

1044th. 104. 21223

1044th. 104. 21223

1
67 4402

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 4402

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

RICHARD ELMO BROWN

2. DATE AND HOUR PRONOUNCED DEAD

4-30-67

3:20 PM M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)44
99 UNION MEMORIAL HOSPITAL - DOA4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1632 Abbotston Street 9-07

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

Jan. 25, 1938

9. AGE (In years
last birthday)

29

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Lenord Paper Company

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

James W. Brown

14. MOTHER'S MAIDEN NAME

Mary F. Whitcomb

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

220-34-7360

17. INFORMANT

ADDRESS

Mr. James W. Brown Reisterstown, Md.

18.

E 981 X I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Gunshot wound of head

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Sidewalk

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

1526 Carswell Avenue

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
4 30 '67 1:55

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Shot during altercation 9-07

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

WERNER U. SPITZ, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

5-1-67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

5/4/67

23C. NAME OF CEMETERY or CREMATORY

Pleasant Grove Cemetery

23D. LOCATION

Boring, Md.

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

MAY 5 1967

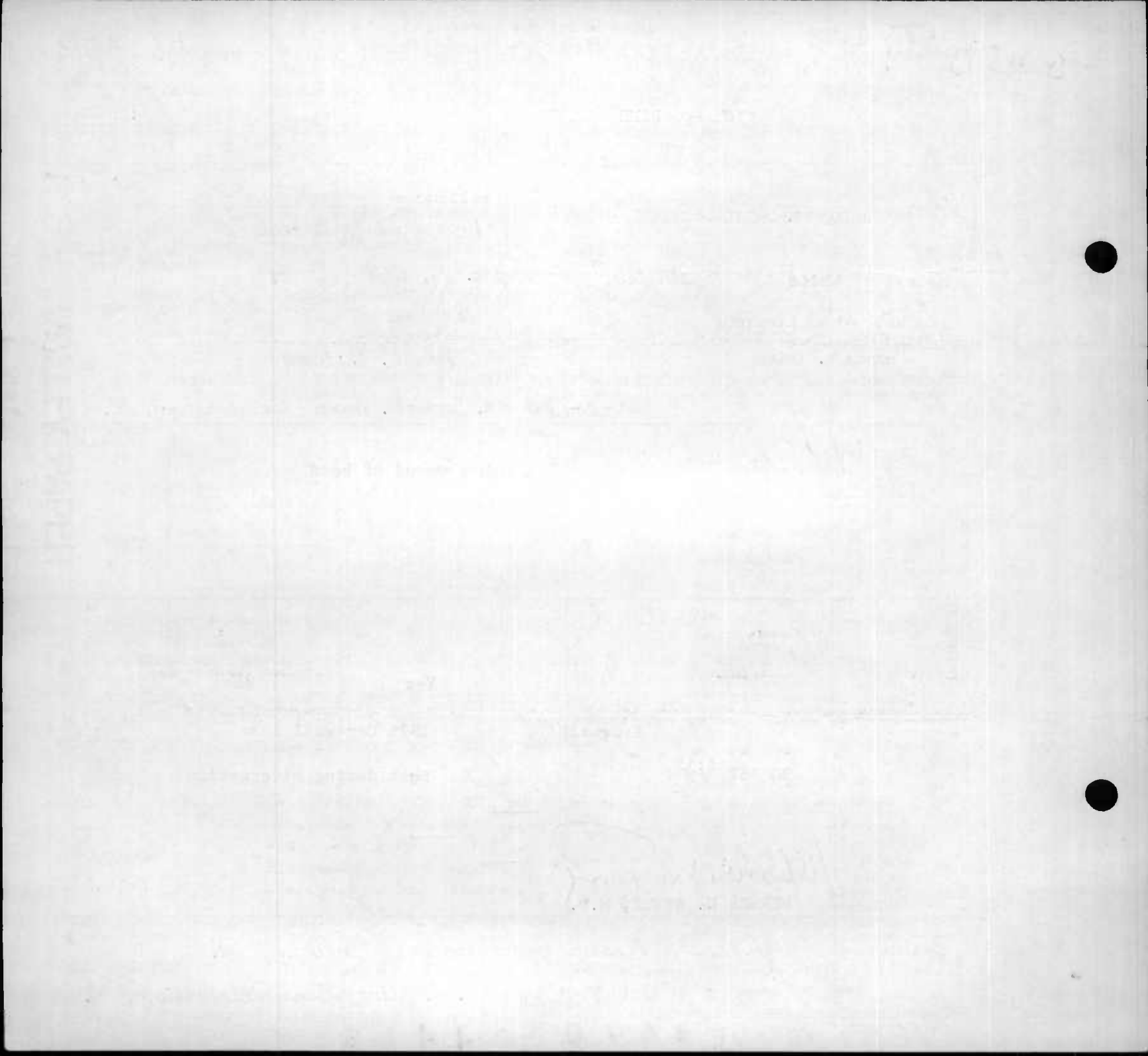
24B. NAME OF REGISTRAR

P. B. E. F. J. E. F.

24C. FUNERAL DIRECTOR

J. F. Eline & Sons Reisterstown, Md.

ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|
| CERTIFICATE OF DEATH | | | | | Registered No. 67 4403 | | | | |
| BIRTH NO. 67 4403 | | | | | M.E. CASE NO. | | | | |
| 1. NAME OF DECEASED
(Type or Print) <u>Grace F Martin</u> | | | | | 2. DATE AND HOUR OF DEATH
<u>MAY 5, 1967</u> <u>1645</u> A.M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>3709 W. Mulberry</u>
<u>00</u> | | | | | A. STATE <u>Balto Co.</u> | | | | |
| (If not in hospital or institution, give street address or location) | | | | | B. COUNTY | | | | |
| 5. SEX <u>F</u> | | | | | 6. RACE <u>W</u> | | | | |
| 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<u>Married</u> | | | | | 8. DATE OF BIRTH
<u>Sept 28, 1886</u> | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | | |
| 11. BIRTHPLACE (State or foreign country)
<u>Maryland</u> | | | | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | | | |
| 13. FATHER'S NAME
<u>John Stoner</u> | | | | | 14. MOTHER'S MAIDEN NAME
<u>Mary Krinen</u> | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>No</u> | | | | | 16. SOCIAL SECURITY NO.
<u>204-01-5132</u> | | | | |
| 17. INFORMANT
<u>Mrs Grace Coffman</u> | | | | | ADDRESS
<u>813 Wodgewood</u>
<u>BALTO 29</u> | | | | |
| 18. <u>420.01</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
<u>arteriosclerotic heart disease</u> | | | | | CAUSE OF DEATH
(A) DUE TO
<u>arteriosclerotic heart disease</u> | | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | (B) DUE TO
<u>generalized arteriosclerosis</u> | | | | |
| (C) DUE TO | | | | | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION
<u>0</u> | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | |
| 20A. AUTOPSY? (Yes or No) | | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | |
| 21F. HOW DID INJURY OCCUR? | | | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>3-11-1950</u> 19 to <u>5-1-67</u> 19, that (I) (we) last saw the deceased alive on <u>4-26-67</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
<u>Harry S. Gimbel</u> | | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | | |
| 23B. DATE SIGNED
<u>5-1-67</u> | | | | | | | | | |
| 23C. PHYSICIAN'S NAME (Type)
<u>HARRY S. GIMBEL</u> | | | | | 23D. ADDRESS
<u>4605 W. W. Ave - Balto 29 Md</u> | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | | | | 24B. DATE
<u>May 4/67</u> | | | | |
| 24C. NAME OF CEMETERY OR CREMATORY
<u>Harbaughs Cem</u> | | | | | 24D. LOCATION (City, town, or county) (State)
<u>Franklin Co Penna</u> | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>MAY 5 1967</u> | | | | | 25B. NAME OF REGISTRAR
<u>Robert E. Farber</u> | | | | |
| 25C. FUNERAL DIRECTOR
<u>J. F. Elmer & Sons</u> | | | | | ADDRESS
<u>Reisterstown Md</u> | | | | |

Small part of the
main structure

2-12-1910

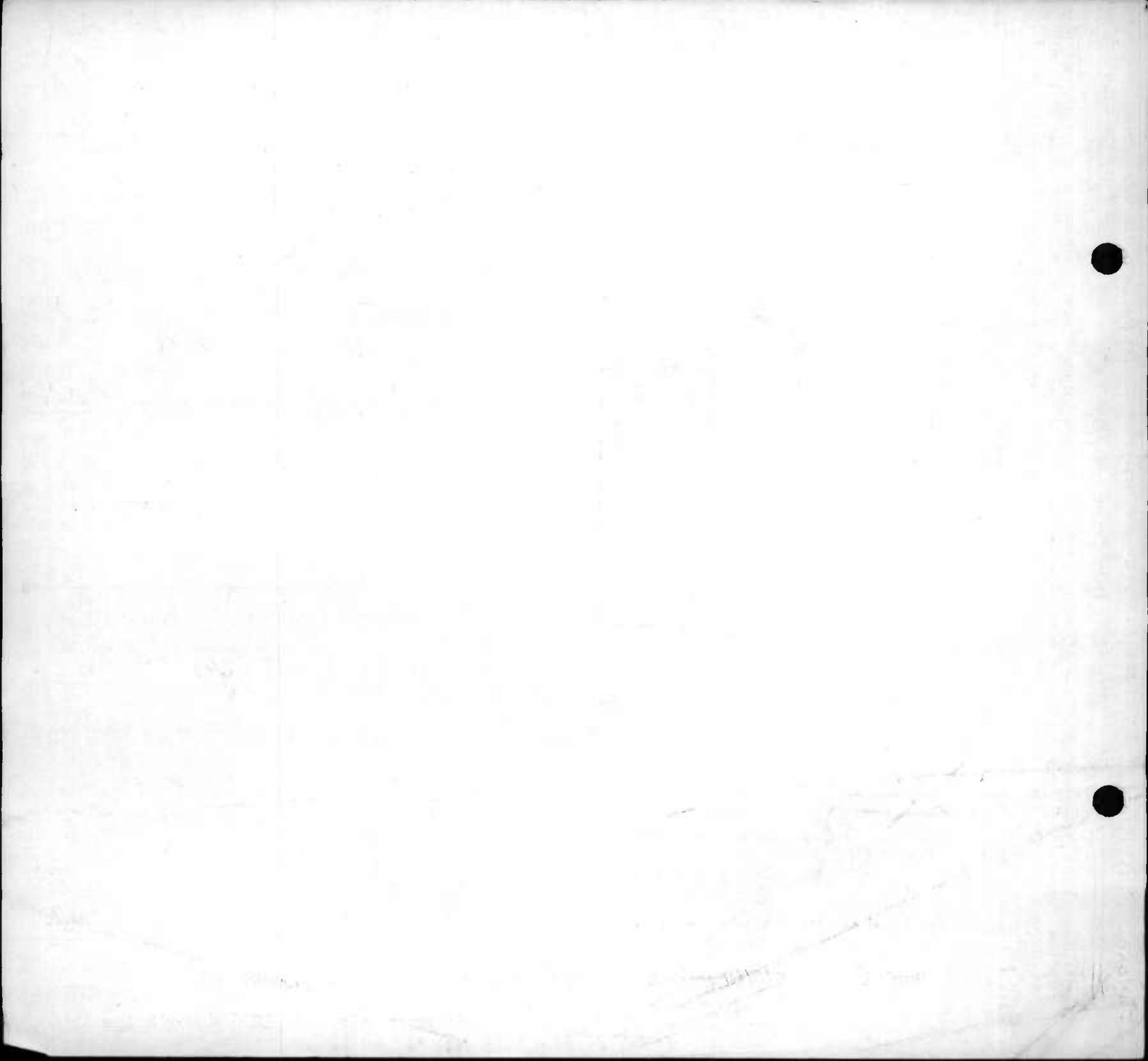
2-12-1910
1910 - 1911

2-12-1910
1910 - 1911

Funeral Director: Important
GET MEDICAL EXAMINER'S APPROVAL

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|------------------|--|-----------------------------|--|---|
| BIRTH NO. 67 4404 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 4404 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) Annie Orrell Johnson | | 2. DATE AND HOUR OF DEATH
MAY 1, 1967 2:45 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
34 Bon Secours Hospital | | A. STATE Maryland B. COUNTY 16-03 | | | |
| (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore 21223 | | | |
| D. STREET ADDRESS (If rural, give location)
929 Vincent Street | | | | | |
| 5. SEX
FE | 6. RACE
Negro | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
SEPARATED | 8. DATE OF BIRTH
3/17/22 | 9. AGE (In years lost birthday)
41 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Virginia | |
| 13. FATHER'S NAME
Leonard Masley | | 14. MOTHER'S MAIDEN NAME
Mildred Marshall | | | |
| 15. Was Deceased Ever in U. S. Armed Forces (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
(Mother) Mildred Banks - Mount Street | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of death, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
581.01
Jaundice
Acute fatty liver etiology? | | CAUSE OF DEATH
(A) DUE TO
(B) DUE TO
(C) | | INTERVAL BETWEEN ONSET AND DEATH
hours | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) state the UNDERLYING CONDITION last.
II
Acute pulmonary edema | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATABLE TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from MAY 1 1967 to MAY 1 1967, that (I) (we) lost saw the deceased alive on MAY 1 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Amable A. Mendoza M.D. | | | | 23B. DATE SIGNED
MAY 1, 1967 | |
| 23C. PHYSICIAN'S NAME (Type)
AMABLE A. MENDOZA M.D. | | | | 23D. ADDRESS
BON SECOURS HOSPITAL | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
5/6/67 | | 24C. NAME OF CEMETERY or CREMATORY
Mt Calvary Cemetery | |
| 24D. LOCATION
A A County Md | | 25A. DATE REC'D BY HEALTH DEPT.
MAY 5 1967 | | | |
| 25B. NAME OF REGISTRAR
Robert E. Fisher | | 25C. FUNERAL DIRECTOR
Adolphus Halstead 1206 W North Ave | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | BALTIMORE CITY DEPARTMENT | |
|--|-------------------------|---|------------------------------------|---|---|
| BIRTH NO. 67 4405 | | | | Registered No. 67 4405 | |
| M.E. CASE NO. | | | | 2. DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED
(Type or Print) GANTT, Thornton | | | | 5/4/67 6:05 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION
Baltimore City Hospitals
4940 Eastern Ave.
Baltimore, Maryland #21224 | | | | A. STATE Maryland
B. COUNTY 14-03 | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | | | | D. STREET ADDRESS (If rural, give location)
1827 Druid Hill Ave. | |
| 5. SEX
Male | 6. RACE
Negro | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married | 8. DATE OF BIRTH
5-24-77 | 9. AGE (In years
last birthday)
89 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 13. FATHER'S NAME
Thomas Gantt | | 14. MOTHER'S MAIDEN NAME
Elizabeth | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
217-263222 | | 17. INFORMANT
BCH: Records 4940 Eastern Ave. Baltimore, Md. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
450.141002.1
CARDIO RESPIRATORY ARREST
post operative status (2) leg. Amputation | | | | INTERVAL BETWEEN ONSET AND DEATH
1 day | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) DUE TO
Generalized atherosclerotic vascular disease. | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | Pulmonary Tuberculosis | |
| 19A. DATE OF OPERATION
5/3/67 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
gangrene @ foot | | 20A. AUTOPSY? (Yes or No)
YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
YES | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 22. I certify that (I) (this hospital) attended the deceased from 5/128/66 to 5/4/1967 , that (I) (we) last saw the deceased alive on 5/4/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | 23A. SIGNATURE
Pablo Trefogli | | 23B. DATE SIGNED
5-4-67 | |
| 23C. PHYSICIAN'S NAME (Type)
PABLO TREFOGGI | | 23D. ADDRESS
BCH
4940 Eastern Ave. Baltimore, Maryland #21224 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
5-8-67 | | 24C. NAME OF CEMETERY or CREMATORY
St. Auburn Cem. | |
| 24D. LOCATION (City, town, or county) (State)
Balto. Md. | | 25A. DATE REC'D BY HEALTH DEPT.
MAY 5 1967 | | | |
| 25B. NAME OF REGISTRAR
Pablo Trefogli | | 25C. FUNERAL DIRECTOR
Kelson Funeral Home 1348 Calhoun St. | | | |

Can Property Asset
for the City of
Harrisburg

Quoted in a letterhead
to local news

Editorial: The
Harrisburg

2/2/81 2/2/81

2/1/81 2/1/81

Box

8-11-81
INCO 10-1-81

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | Registered No. 67 4406 | |
|--|---------------------|---|------------------------------------|--|----------------------------|--|-----------------------------|
| BIRTH NO. 67 4406 | | M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED
(Type or Print) Tawney, Elizabeth M. | | | | 2. DATE AND HOUR OF DEATH
5-1-67 7:05 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
34 Bon Secours Hosp. | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY 27-05 | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | | | |
| | | | | D. STREET ADDRESS (If rural, give location)
3903 Walnut Ave | | | |
| 5. SEX
F | 6. RACE
W | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widowed | 8. DATE OF BIRTH
7/03/95 | 9. AGE (In years last birthday)
71 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
PennA. Philadelphia | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME
John Sherman | | | | 14. MOTHER'S MAIDEN NAME
Martha Chennault | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
no | | 16. SOCIAL SECURITY NO.
215 50 3382 | | 17. INFORMANT ADDRESS
Mr Douglas S. Tawney 3903 Walnut Ave. | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
I
Intra-abdominal Ca
Intestinal Obstruction | | | | CAUSE OF DEATH
INTERVAL BETWEEN ONSET AND DEATH | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) lost saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
S. V. Gancoso | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
May 1, 1967 | |
| 23C. PHYSICIAN'S NAME (Type)
S. V. Gancoso | | | | 23D. ADDRESS
M.D. Bon Secours Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
5/4/67 | | 24C. NAME OF CEMETERY or CREMATORY
Parkwood Cemetery | | 24D. LOCATION (City, town, or county) (State)
Baltimore Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 5 1967 | | 25B. NAME OF REGISTRAR
Robert E. Tawney | | 25C. FUNERAL DIRECTOR ADDRESS
HENRY SANDER & SONS INC.
4 BALTIMORE MARYLAND | | | |

Entire abdominal cavity
is distended with fluid

A. V. Bennett

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | |
|--|-------------------------|--|--|--|--|--|--|--|--|--|
| CERTIFICATE OF DEATH | | | | | Registered No. <u>67 4407</u> | | | | | |
| BIRTH NO. <u>67 4407</u> | | M.E. CASE NO. | | | 1. NAME OF DECEASED
(Type or Print) <u>ABBOTT, ELSIE E.</u> | | | 2. DATE AND HOUR OF DEATH
<u>4 MAY 1967</u> <u>1250 P.</u> | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <u>MARYLAND</u> B. COUNTY <u>27-06</u> | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<u>UNION MEMORIAL HOSPITAL</u> | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>BALTIMORE</u> | | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location)
<u>6302 MC. CLEEN BLVD.</u> | | | | | |
| 5. SEX
<u>FEMALE</u> | 6. RACE
<u>WHITE</u> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<u>WIDOWED</u> | | 8. DATE OF BIRTH
<u>01-22-89</u> | 9. AGE (In years last birthday)
<u>78</u> | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>HOUSEWIFE</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>—</u> | | 11. BIRTHPLACE (State or foreign country)
<u>MARYLAND</u> | | | 12. CITIZEN OF WHAT COUNTRY?
<u>AMERICAN</u> | | |
| 13. FATHER'S NAME
<u>THOMAS HUBBARD</u> | | | | | 14. MOTHER'S MAIDEN NAME
<u>MARY JONES</u> | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>NO</u> | | | 16. SOCIAL SECURITY NO.
<u>WA 326 183 0891</u> | | 17. INFORMANT
<u>THELMA D. ABBOTT 6302 McCLEAN BLVD.</u> | | | ADDRESS | | |
| 18. <u>200.1 I</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
<u>APLASTIC ANEMIA</u>
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | (A) DUE TO
<u>LYMPHOSARCOMA</u>
(B) DUE TO
<u>—</u>
(C) <u>—</u> | | | INTERVAL BETWEEN ONSET AND DEATH
<u>2 MONTHS</u>
<u>1 YEAR</u> | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | |
| 19A. DATE OF OPERATION
<u>0</u> | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No)
<u>NO</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>3-24</u> 19 <u>67</u> to <u>5-4</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>5-4</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | |
| 23A. SIGNATURE
<u>Fridtjofur Bjornsson M.D.</u> | | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | 23B. DATE SIGNED
<u>5-4 '67</u> | | |
| 23C. PHYSICIAN'S NAME (Type)
<u>FRIDTJOFUR BJORNSSON</u> | | | | | 23D. ADDRESS
<u>UNION MEMORIAL HOSPITAL</u> | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | 24B. DATE
<u>5/6/67</u> | | 24C. NAME OF CEMETERY or CREMATORY
<u>MORELAND MEMORIAL</u> | | | 24D. LOCATION (City, town, or county) (State)
<u>TAYLOR AVE BALTO. MD</u> | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>MAY 5 1967</u> | | | 25B. NAME OF REGISTRAR
<u>Robert E. Taylor</u> | | | 25C. FUNERAL DIRECTOR ADDRESS
<u>DIPRALE BRISING 7110 BELAIR RD (C)</u> | | | | |

1948

6302 MC CLENN BLVD
BALTIMORE

UNION MEMORIAL HOSPITAL

61-52-89 78

WHITE MALE

MARY JONES

THOMAS HARRIS

APLASTIC ANEMIA

LYMPHOZARCOMA

1 YEAR

2 MONTHS

NO

2-1

2-24

2-1

2-1

V

FRIDTJOF A. GARNSON

UNION MEMORIAL HOSPITAL

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

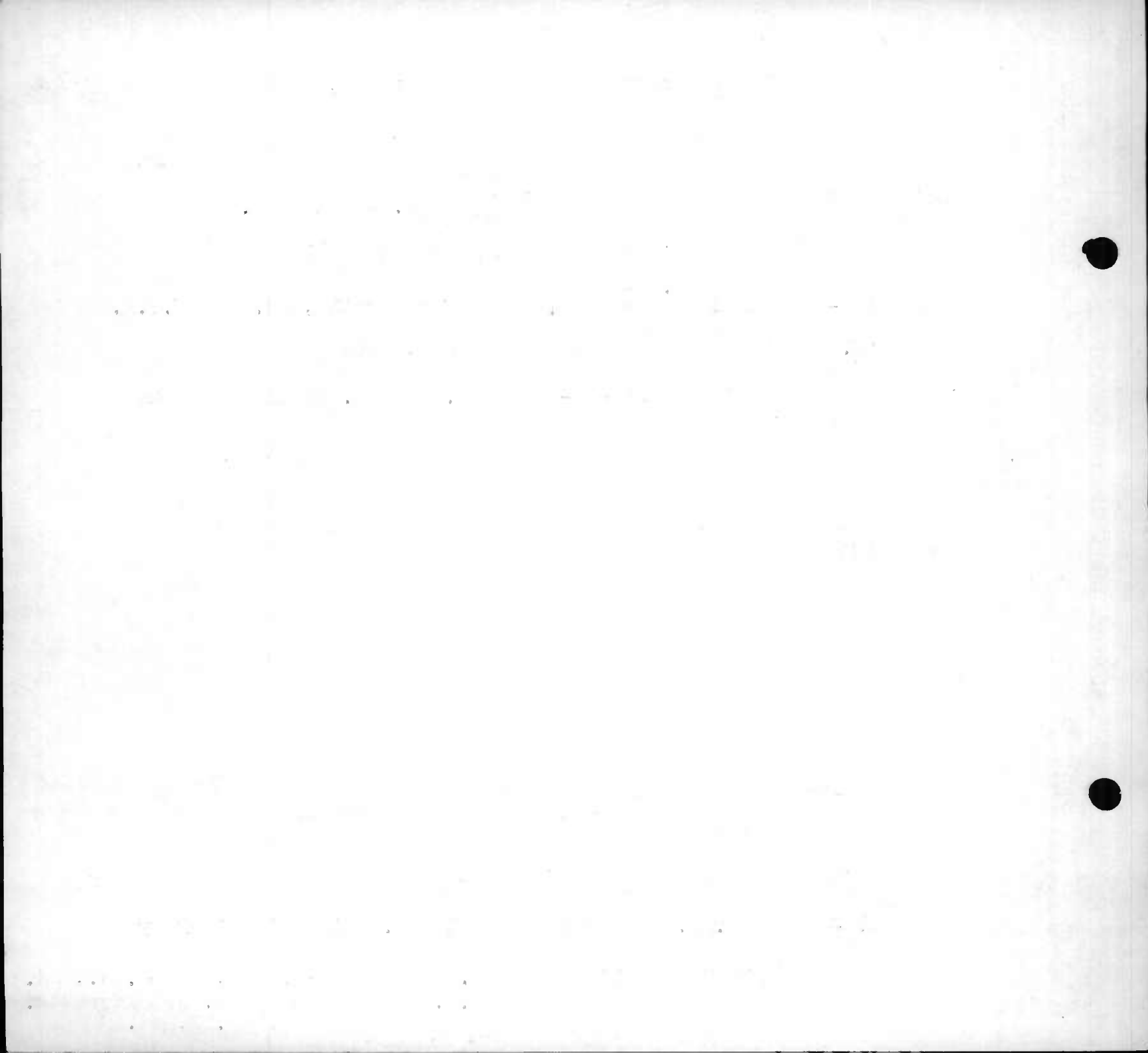
| BIRTH NO. 67 4408 | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | Registered No. 67 4408 | |
|--|----------------|--|--|--|--|--|--|
| 1. NAME OF DECEASED
(Type or Print) SCHUYLER, ELIZABETH | | | | 2. DATE AND HOUR OF DEATH
5/3/67 1230 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION
48 MARYLAND GENL HOSPITAL
(If not in hospital or institution, give street address or location) | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND B. COUNTY 28-04
C. CITY OR TOWN Baltimore 21229
D. STREET ADDRESS 500 WESTGATE Rd.
(If rural, give location) | | | |
| 5. SEX
F | 6. RACE
Cau | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
MARRIED | 8. DATE OF BIRTH
9-15-89 | 9. AGE (In years last birthday)
77 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | |
| 11. BIRTHPLACE (State or foreign country)
Md. | | | 12. CITIZEN OF WHAT COUNTRY?
USA | | | 13. FATHER'S NAME
JAMES T MULLIKIN | |
| 14. MOTHER'S MAIDEN NAME
EMMA PRICE | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | |
| 17. INFORMANT | | ADDRESS | | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
154X1
Pneumonia | | CAUSE OF DEATH
(A) DUE TO
(B) DUE TO
(C) DUE TO
Metastatic carcinoma 2 months
of rectum =
partial intestinal obstruction 10 days | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION
4-6-67 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
intestinal obstruction | | 20A. AUTOPSY? (Yes or No)
(No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office, etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | |
| 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (it) (this hospital) attended the deceased from 4-1-67 19 to 5-3-67 19 that (it) (we) last saw the deceased alive on 5-3-67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
Robert M. Beazley | | | | 23B. DATE SIGNED
5/3/67 | | 23C. PHYSICIAN'S NAME (Type)
Robert M. Beazley | |
| 23D. ADDRESS
M.D.
Maryland Genl Hosp | | 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | | | | |
| 24B. DATE
5-6-1967 | | 24C. NAME OF CEMETERY or CREMATORY
Lorraine | | 24D. LOCATION (City, town, or county) (State)
Baltimore Maryland | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 5 1967 | | 25B. NAME OF REGISTRAR
Robert E. Taylor M.D. | | 25C. FUNERAL DIRECTOR
Witzke Funeral Dir. | | ADDRESS
4101 Edmondson Ave. | |

[Faint, illegible text and markings, possibly bleed-through from the reverse side of the page. Some faint words like "REPORT" and "TABLE" are visible.]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Certificate of Death | | Registered No. 67 4409 | |
|--|--------------|--|--------------------------------|---|----------------------------|--|-----------------------------|
| BIRTH NO. 67 4409 | | M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | | | Albert Glendye Harkins | | May 2, 1967 15 P. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location) | | | | A. STATE B. COUNTY | | | |
| 43 South Baltimore General Hosp | | | | Maryland | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| | | | | Baltimore | | | |
| | | | | D. STREET ADDRESS (If rural, give location) | | | |
| | | | | 3700 N. Charles St. | | | |
| 5. SEX
M | 6. RACE
W | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married | 8. DATE OF BIRTH
12/10/1884 | 9. AGE (In years lost birthday)
82 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| Executive-President Products Co. | | Md. Steel | | Forest Hill, Md. | | U.S.A. | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| George A. Harkins | | | | Sara Quinlan | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| No | | 212-30-3721 | | Mrs. Edith D. Harkins | | (Same) | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| 420.1 I | | | | Myocardial infarction | | inst | |
| ANTECEDENT CAUSES | | | | (A) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) DUE TO | | Ant. Sel. Hrt. Dis. | |
| | | | | (C) DUE TO | | undet. | |
| II | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| D | | | | No | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan. 19 63 to May 2 19 67, that (I) (we) last saw the deceased alive on May 1 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | | |
| K. A. Peter K. A. van Berkum M.D. | | | | 5/4/67 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| K. A. Peter K. A. van Berkum M.D. | | | | 100 W. University Parkway | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| Burial | | 5/5/1967 | | Druid Ridge Cem. | | Pikesville, Balto. Co., Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| MAY 5 1967 | | Robert E. Jenkins | | H.W. Jenkins & Sons Co. | | 4905 York Rd. Balto. 12, Md. | |



T. 400

| BIRTH NO. 67 4410 | | BALTIMORE CITY HEALTH DEPARTMENT | | 67 4410 | |
|---|-------------------------|--|--|---|---|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | Registered No. | |
| 1. NAME OF DECEASED
(Type or Print)
CHARLES HENRY TWELE | | | | 2. DATE AND HOUR PRONOUNCED DEAD
5-3-67 1:45 PM M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
UNION MEMORIAL HOSPITAL - DOA | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 3005 Guilford Avenue 21218 | |
| 5. SEX
Male | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)
Single | 8. DATE OF BIRTH
July 29, 1900 | 9. AGE (In years last birthday)
67 | If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired - Electrician Electric | | | 11. BIRTHPLACE (State or foreign country)
Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. |
| 13. FATHER'S NAME
Frederick W. Twele | | | 14. MOTHER'S MAIDEN NAME
Mary Flaherty | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown), (If yes, give war or dates of service)
Yes WWII | | | 16. SOCIAL SECURITY NO.
213-03-5115 | | |
| 17. INFORMANT
Mrs. Joseph Nolty | | | ADDRESS 340 E. University Pkwy. | | |
| 18. CAUSE OF DEATH
E982X1
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Stab wound of chest
(A) DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) DUE TO
(C) DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
Apartment | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
630 Gutman Avenue | |
| 21D. TIME OF INJURY (APPROX.)
5 3 '67 1:30 PM | | 21E. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR?
Stabbed during altercation | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>
CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>
ACTUAL SIGNATURE Russell S. Fisher M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
EXAMINER'S NAME (Type) RUSSELL S. FISHER, M.D. ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>
DATE SIGNED 5-3-67 | | | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 23B. DATE
5/8/1967 | | 23C. NAME of CEMETERY or CREMATORY
Baltimore National | |
| 24A. DATE REC'D BY HEALTH DEPT.
MAY 5 1967 | | 24B. NAME OF REGISTRAR
Robert E. Farber | | 24C. FUNERAL DIRECTOR
H.W. Jenkins & Sons Co. 4905 York Rd. Baltimore 12, Md. | |

N8752670004410



WILLIAM F. FORD

WILLIAM F. FORD

WILLIAM F. FORD

WILLIAM F. FORD

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WILLIAM F. FORD

WILLIAM F. FORD

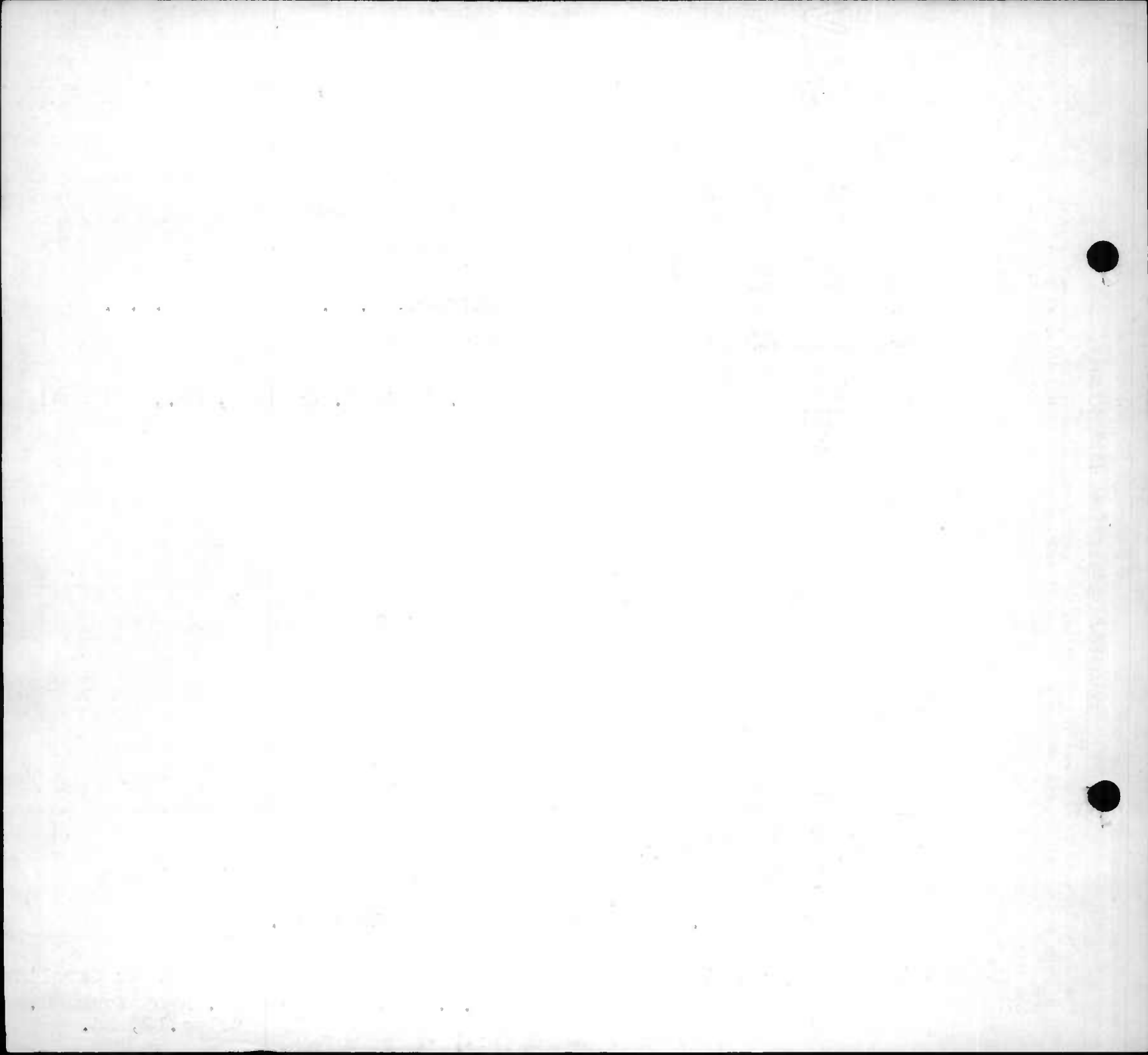
WILLIAM F. FORD

WILLIAM F. FORD

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 67 4411 | |
|--|---------------------|--|---------------------------------------|--|--|
| CERTIFICATE OF DEATH | | | | Registered No. 67 4411 | |
| BIRTH NO. 67 4411 | | M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) Flora Chisolm Walker | |
| 2. DATE AND HOUR OF DEATH
May 4, 1967 | | 2:15 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
4400 Underwood Road | | A. STATE Maryland
B. COUNTY Baltimore
C. CITY OR TOWN (If outside city limits, write RURAL and give township) 27-11
D. STREET ADDRESS (If rural, give location) 4400 Underwood Road | | | |
| 5. SEX
F | 6. RACE
W | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widowed | 8. DATE OF BIRTH
10/31/1879 | 9. AGE (In years last birthday)
87 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY
Own Home | | 11. BIRTHPLACE (State or foreign country)
Gifford, S. C. | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
John James Chisolm | | 14. MOTHER'S MAIDEN NAME
Julia Smith | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
Mrs. Willis E. Johnson, Jr., (Same) | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
491 X1
Broch-pneumonia | | CAUSE OF DEATH
(A) DUE TO
(B) DUE TO
(C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH
3 days | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
General Arteriosclerosis | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
no | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1955 to May 4, 1967 that (I) (we) last saw the deceased alive on May 3, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
William G. Helfrich | | | | 23B. DATE SIGNED
4 May 67 | |
| 23C. PHYSICIAN'S NAME (Type)
William G. Helfrich | | 23D. ADDRESS
5006 Roland Ave. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
5/6/1967 | | 24C. NAME of CEMETERY or CREMATORY
Beach Branch | |
| 24D. LOCATION (City, town, or county) (State)
South Carolina | | 25A. DATE REC'D BY HEALTH DEPT.
MAY 5 1967 | | | |
| 25B. NAME OF REGISTRAR
Robert E. Jenkins | | 25C. FUNERAL DIRECTOR ADDRESS
H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md. | | | |



2521
 For Approval by Medical Examiner
 FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department | | | | BIRTH NO. 67 4412 | | Registered No. 67 4412 | |
|--|---------------------|---|---------------------------------------|---|----------------------------|---|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) McComas, MARGARET E. | | | | 2. DATE AND HOUR OF DEATH
5/3/67 17:55 p.m. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD. B. COUNTY BALTIMORE | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
38 UNIVERSITY HOSPITAL | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Towson 53-00 | | | |
| D. STREET ADDRESS (If rural, give location)
21 Charles Lane | | | | | | | |
| 5. SEX
F | 6. RACE
W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
MARRIED | 8. DATE OF BIRTH
10-17-1899 | 9. AGE (In years last birthday)
67 | II Under 1 Yr. Months Days | II Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HW | | 10B. KIND OF BUSINESS OR INDUSTRY
OWN HOME | | 11. BIRTHPLACE (State or foreign country)
MD. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Wm. Stephens | | | | 14. MOTHER'S MAIDEN NAME
Lavinia Sipes | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
2B-1-1255B | | 17. INFORMANT
J. ROSS McComas (SAME) | | ADDRESS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
Dissecting Aortic Aneurysm | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Attempted repair of dissection | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION
5/3/67 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
alone | | 20A. AUTOPSY? (Yes or No)
No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 5/3/67 19 to 5/3/67 19, that (I) (we) last saw the deceased alive on 5/3/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
B.N. Irani | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
5/3/67 | |
| 23C. PHYSICIAN'S NAME (Type)
B.N. IRANI | | | | 23D. ADDRESS
M.D. University Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
5/6/1967 | | 24C. NAME OF CEMETERY OR CREMATORY
Loudon Park | | 24D. LOCATION (City, town, or county) (State)
Baltimore Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 5 1967 | | 25B. NAME OF REGISTRAR
Robert E. Farber | | 25C. FUNERAL DIRECTOR ADDRESS
H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md. | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 67 4413 | | BALTIMORE CITY HEALTH DEPARTMENT | | Register No. 67 4413 | |
|---|---------------------|---|--|--|---|
| M.E. CASE NO. | | | CERTIFICATE OF DEATH | | |
| 1. NAME OF DECEASED
(Type or Print) Margaret Kable Winslow | | | 2. DATE AND HOUR OF DEATH
3 May 1967 2:50 A.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
38 University Hospital | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY (Balt. city)
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
4608 Roland Avenue | | |
| 5. SEX
F | 6. RACE
W | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
widow | 8. DATE OF BIRTH
7/29/75 | 9. AGE (In years last birthday)
91 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
nurse | | 10B. KIND OF BUSINESS OR INDUSTRY
NURSING | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | | 13. FATHER'S NAME
Llewellyn Massey | | |
| 14. MOTHER'S MAIDEN NAME
Emilie Thomas | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
no | | |
| 16. SOCIAL SECURITY NO.
220-44-1554 | | | 17. INFORMANT ADDRESS
hospital records | | |
| 18. CAUSE OF DEATH | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)
Myocardial infarction 24 hrs. | | | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Gastro intestinal hemorrhage 12 hrs. | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Arteriosclerotic CVD | | | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that the (this hospital) attended the deceased from 5/2 19 67 to 5/3 19 67 , that the (we) last saw the deceased alive on 5/3 19 67 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. the (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Susan L. Howard | | | | 23B. DATE SIGNED
5/3/67 | |
| 23C. PHYSICIAN'S NAME (Type)
Susan L. Howard | | | | 23D. ADDRESS
University Hospital | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
5/5/1967 | | 24C. NAME OF CEMETERY OR CREMATORY
Friends Burial Ground | |
| 24D. LOCATION (City, town, or county) (State)
Baltimore, Md. | | 25A. DATE REC'D BY HEALTH DEPT.
MAY 5 1967 | | | |
| 25B. NAME OF REGISTRAR
Robert E. Jenkins | | 25C. FUNERAL DIRECTOR ADDRESS
H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md. | | | |

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 4414 | |
|--|-------------------------|--|--|--|--|
| BIRTH NO. 67 4414 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) Mae A. Alexander | | 2. DATE AND HOUR OF DEATH
May 2, 1967 | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
21 N Kossuth St | | A. STATE Md. B. COUNTY Baltimore | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | | | |
| | | D. STREET ADDRESS (If rural, give location)
21 N. Kossuth St. | | | |
| 5. SEX
Female | 6. RACE
Cauc. | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widowed | 8. DATE OF BIRTH
Oct. 16, 1889 | 9. AGE (In years last birthday)
77 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Baltimore Maryland | |
| 13. FATHER'S NAME
John Popp | | | 14. MOTHER'S MAIDEN NAME | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
no | | 16. SOCIAL SECURITY NO.
215-22-2291A | | 17. INFORMANT ADDRESS
William N. Karcher 21 N. Kossuth St. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)
Coronary Thrombosis | | CAUSE OF DEATH
(A) DUE TO
Coronary Thrombosis | | INTERVAL BETWEEN ONSET AND DEATH
instant | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO
Arteriosclerosis (V.V.) | | year | |
| (C) _____ | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan 1963 to May 2 1967 , that (I) (we) last saw the deceased alive on May 1 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Dr. John C. Pound | | | | 23B. DATE SIGNED
5/3/67 | |
| 23C. PHYSICIAN'S NAME (Type)
Dr. John C. Pound | | 23D. ADDRESS
3325 Frederick Ave | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
5-5-1967 | | 24C. NAME OF CEMETERY or CREMATORY
Greenmount | |
| 24D. LOCATION (City, town, or county) (State)
Baltimore Maryland | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 5 1967 | | 25B. NAME OF REGISTRAR
Witzke F.D. | | 25C. FUNERAL DIRECTOR ADDRESS
4101 Edmondson Ave. | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|--|-----------------------------|--|--|--|--|---|-----------------------|
| BIRTH NO. 67 4415 | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | Registered No. 67 4415 | |
| 1. NAME OF DECEASED
(Type or Print) <i>Anna Whitehead</i> | | | | 2. DATE AND HOUR OF DEATH
<i>May 4, 1967</i> M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<i>00 1840 E. Chase</i> | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <i>MD</i>
B. COUNTY <i>8-07</i>
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<i>Baltimore</i>
D. STREET ADDRESS (If rural, give location)
<i>1840 E. Chase St.</i> | | | |
| 5. SEX
<i>Female</i> | 6. RACE
<i>Caucasian</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
<i>Widowed</i> | 8. DATE OF BIRTH
<i>Oct 3, 1891</i> | 9. AGE (in years last birthday)
<i>75</i> | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Housewife</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<i>Baltimore, MD</i> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME
<i>Robert Brown</i> | | | | 14. MOTHER'S MAIDEN NAME
<i>Louise Miller</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>No</i> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
<i>Quith Lillo 1840 E Chase St</i> | | ADDRESS | |
| 18. <i>422.11</i>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
<i>Acute Bronchopneumonia</i>
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
<i>Arteriosclerotic cardiovascular disease</i>
<i>Generalized arteriosclerosis</i>

<i>Senility</i> | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>5/3</i> 19 <i>67</i> to <i>5/4</i> 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>5/3</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
<i>Stanley D. Madison, M.D.</i> M.D. | | | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
<i>5/5/67</i> | |
| 23C. PHYSICIAN'S NAME (Type)
<i>Stanley D. Madison, M.D.</i> M.D. | | | | 23D. ADDRESS
<i>2444 E Biddle St, Balt, Md</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 24B. DATE
<i>May 18/67</i> | | 24C. NAME of CEMETERY or CREMATORY
<i>McCalvary Cem</i> | | 24D. LOCATION (City, town, or county) (State)
<i>A.A. County Md.</i> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<i>MAY 5 1967</i> | | 25B. NAME OF REGISTRAR
<i>Robert E. F...</i> | | 25C. FUNERAL DIRECTOR
<i>Frank E. Elickson</i> | | ADDRESS
<i>1129 N. Calvert</i> | |

15th Nov. 1911
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 4416 | |
|---|------------------|---|---------------------------------|--|--|
| BIRTH NO. 67 4416 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) Cleo Leak | | 2. DATE AND HOUR OF DEATH
5/8/67 12:15 p.m. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
University of Maryland Hospital | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE Md.
B. COUNTY Baltimore
C. CITY OR TOWN (If outside city limits, write RURAL and give township) 9-09
D. STREET ADDRESS (If rural, give location) 1720 Asquith St | | | |
| 5. SEX F | 6. RACE N | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH 3/14/15 | 9. AGE (In years last birthday) 52 | If Under 1 Yr. Months Days If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY Housewife | | 11. BIRTHPLACE (State or foreign country) N.C. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Henry Asberry | | 14. MOTHER'S MAIDEN NAME Jessie Warrenless | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Norve Leak ADDRESS 1720 Asquith St | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
LEUKEMIA | | CAUSE OF DEATH
(A) DUE TO Leukemia
(B) DUE TO Sy cell Ca / Cx - stage III
(C) | | INTERVAL BETWEEN ONSET AND DEATH | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 5/1/67 to 5/4/67 that (I) (we) last saw the deceased alive on 12:00 midnight 5/4/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Rosevelt Taylor, Jr. M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED 5/5/67 | |
| 23C. PHYSICIAN'S NAME (Type) Rosevelt Taylor, Jr. M.D. | | | | 23D. ADDRESS University Hospital of Maryland | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE 5/9/67 | | 24C. NAME OF CEMETERY OR CREMATORY Carver New Park Laurel Md | |
| 24D. LOCATION (City, town, or county) (State) | | 25A. DATE REC'D BY HEALTH DEPT. | | | |
| 25B. NAME OF REGISTRAR Rosevelt Taylor, Jr. | | 25C. FUNERAL DIRECTOR Frederick E. Eickman ADDRESS 12977 Carver Rd | | | |

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| BALTIMORE CITY HEALTH DEPARTMENT | | | |
|---|--|--|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | |
| BIRTH NO. 67 4417 | | Registered No. 67 4417 | |
| M.E. CASE NO. | | | |
| 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR PRONOUNCED DEAD | |
| HENRY T. LOUX | | 5-3-67 6:45 AM | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION

00 1733 BANK STREET - Amb. Crew #10 | | A. STATE
District of Columbia | |
| | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) | |
| | | D. STREET ADDRESS (If rural, give location) | |
| | | Washington V-48 | |
| | | U. S. Soldiers Home | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH |
| Male | White | Divorced | July 14, 1916. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | |
| Retired | | US Army | |
| 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| Penna. | | USA | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | |
| Henry T. Loux | | Sarah McAndrew | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| Yes WW 2 | | | |
| 17. INFORMANT | | ADDRESS | |
| H.M. Gormley Funeral Home | | 911 Pacific St. Atlantic City, N.J. | |
| 18. CAUSE OF DEATH | | | INTERVAL BETWEEN ONSET AND DEATH |
| E900.07E322.0
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
(A) Fracture of cervical spine
DUE TO | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) _____
DUE TO | | | |
| (C) _____
DUE TO | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Acute ethylism | | | |
| 19A. DATE OF OPERATION | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 2 | | Yes | Yes |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| | | Apartment 1733 Bank Street | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. HOW DID INJURY OCCUR? | |
| Was drinking and apparently fell down stairs | | | |
| 21E. TIME OF INJURY (APPROX.) | (Month) (Day) (Year) (Hour) | 21F. INJURY OCCURRED | 21G. HOW DID INJURY OCCUR? |
| 5 3 '67 ? | m. | WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE | | CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| EXAMINER'S NAME (Type) | | M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| RUSSELL S. FISHER, M.D. | | 5-3-67 | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) | 23B. DATE | 23C. NAME OF CEMETERY or CREMATORY | 23D. LOCATION (City, town, or county) (State) |
| Burial | 5/8/67. | Old Soldiers Cemetery | Washington, D.C. |
| 24A. DATE REC'D BY HEALTH DEPT. | | 24B. NAME OF REGISTRAR | |
| MAY 8 1967 | | Robert E. Farley, M.D. | |
| 24C. FUNERAL DIRECTOR | | ADDRESS | |
| Leona rd J. Ruck, Inc. Balt. Md. 21214 | | | |

N 8051 967 000 4425

WALLACE FORGE

Bm.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 4418 | |
|--|---------------|---|---------------------------|--|---|
| BIRTH NO. 67 4418 | | CERTIFICATE OF DEATH | | 67 4418 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) Louis Meyer | | 2. DATE AND HOUR OF DEATH
5/4/67 12:55 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
44 Union Memorial Hospital | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE Maryland
B. COUNTY Baltimore
C. CITY OR TOWN (If outside city limits, write RURAL and give township) 21214
D. STREET ADDRESS (If rural, give location) 5313 ELKRODE AVENUE | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 10/26/88 | 9. AGE (In years last birthday) 78 | 10. If Under 1 Yr. Months: Days: Hours: Min. 7 Months |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10B. KIND OF BUSINESS OR INDUSTRY Insurance Agent | | 11. BIRTHPLACE (State or foreign country) USA - Balt. Md. | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Edward Meyer | | 14. MOTHER'S MAIDEN NAME Mary WOLF | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or date of service) No | | 16. SOCIAL SECURITY NO. 212-07-2940 | | 17. INFORMANT Mrs. Annie Meyer | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
① Suprapubic Prostatectomy, BPH
② Benign Prostatic Hypertrophy
③ ASHD
④ Pulmonary Emphysema
(A) DUE TO
(B) DUE TO
(C) Aortic Urinary Retention - Benign Prostatic Hypertrophy | | INTERVAL BETWEEN ONSET AND DEATH | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 5/1/67 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Urinary Retention BPH | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (this hospital) attended the deceased from 4/19 1967 to 5/4 1967, that (we) last saw the deceased alive on 5/4 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE David S. Schwartz | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 5/4/67 | |
| 23C. PHYSICIAN'S NAME (Type) DAVID S. SCHWARTZ | | 23D. ADDRESS M.D. THE UNION MEMORIAL HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 5/8/67 | | 24C. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery | |
| 24D. LOCATION Baltimore, Md. | | 25A. DATE REC'D BY HEALTH DEPT. | | | |
| 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214 | | | |
| 25D. ADDRESS | | | | | |

Union Membership History

2313 ELLROBE PLACER

Base White - Mining

10/28/88 JR 2 PMS

History -

U2A - GAT. and U2A

Edward Meyer

Small Work

- ① Springfield (GAT) 824
 - ② GAT - GAT - GAT
 - ③ A24D
 - ④ GAT - GAT - GAT
- A and U2A -
GAT - GAT - GAT

21112 Union History 4084 NO

David A. Abbott

THE U2A - GAT - GAT

U2A - GAT - GAT

CERTIFICATE OF DEATH

M.E. CASE NO.

1. NAME OF DECEASED Jesse
(Type or Print) *Jesse W. Hart*

2. DATE AND HOUR OF DEATH

5/6/67 2:15 pm

M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

31

BALTIMORE CITY HOSPITALS
4940 EASTERN AVENUE
BALTIMORE 21224, MD.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

MARYLAND

C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE

D. STREET ADDRESS (If rural, give location)

945 RODMAN WAY # 21205

5. SEX

MALE

6. RACE

WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

4-30-83

9. AGE (In years lost birthday)

84

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired Meat Cutter

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

LOUIS C. Hart

14. MOTHER'S MAIDEN NAME

ELEANOR DAVIS

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

Unk.

16. SOCIAL SECURITY NO.

216-07-9726

17. INFORMANT

ADDRESS

RECORDS: BCH 4940 EASTERN Avenue #21224

18.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) DUE TO

GI bleeding

(B) DUE TO

esophageal varices

(C) DUE TO

? carcinoma

INTERVAL BETWEEN ONSET AND DEATH

3 days

?

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

YES

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from *4/12* 19 *67* to *5/6* 19 *67*, that (I) (we) last saw the deceased alive on *5/2* 19 *67* and that in *my* (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Monica M. Buckley

M.D.

Attending Phys. ☒

Med. Director ☐

Staff Phys. ☐

23B. DATE SIGNED

5/2

23C. PHYSICIAN'S NAME (Type)

DR. MONICA M. BUCKLEY

M.D.

23D. ADDRESS

4940 EASTERN AVENUE BALTIMORE 21224, MD.

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

5/6/67.

24C. NAME OF CEMETERY or CREMATORY

Gardens of Faith Cemetery

24D. LOCATION

(City, town, or county)

Baltimore, Md.

(State)

25A. DATE REC'D BY HEALTH DEPT.

MAY 8 1967

25B. NAME OF REGISTRAR

Robert E. Taylor

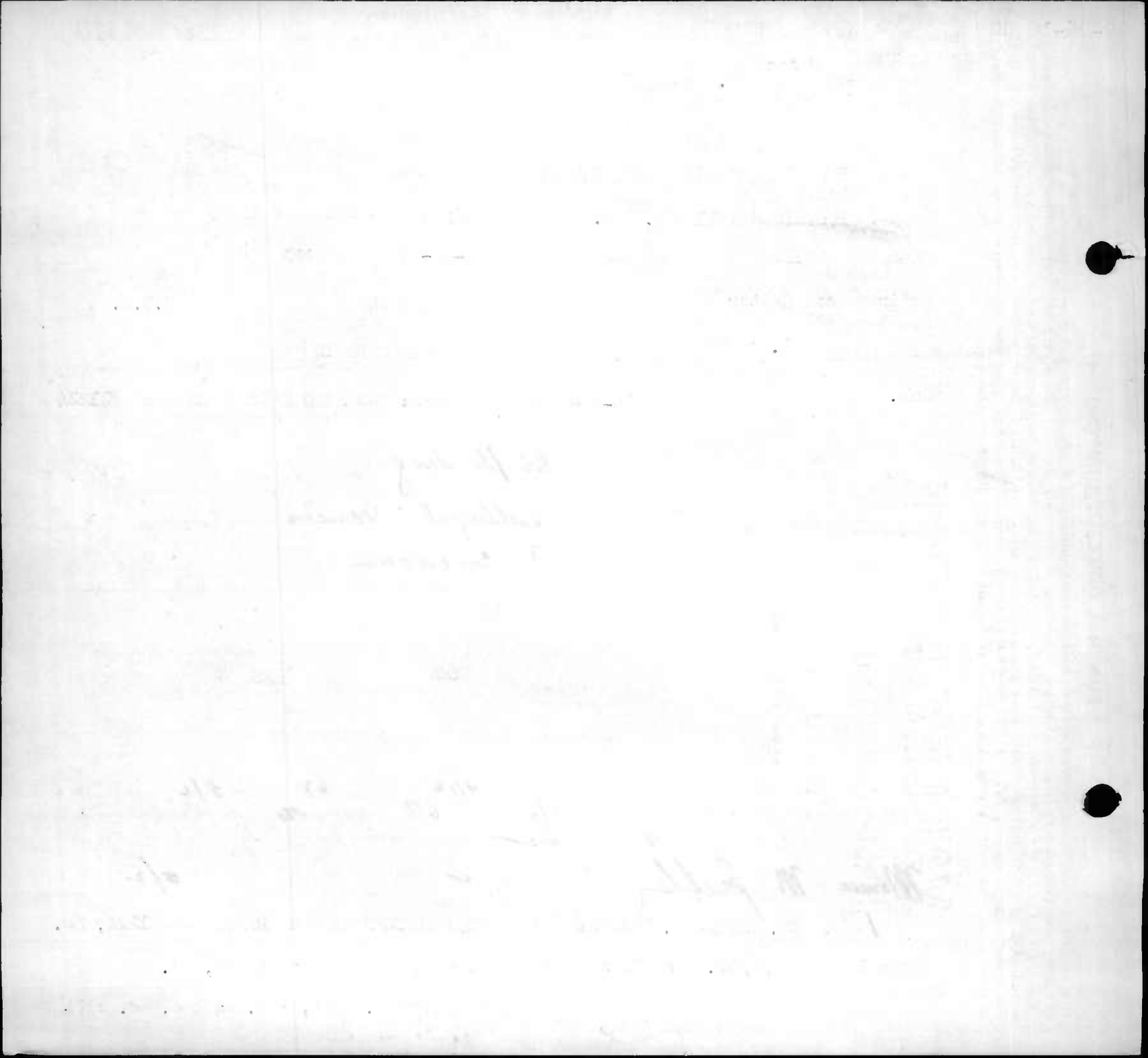
25C. FUNERAL DIRECTOR

Leonard J. Ruck, Inc. Balto. Md. 21214

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Certificate of Death | | Registered No. 67 4420 | |
|--|---|---|--|--|--|--|--|
| BIRTH NO. 67 4420 | | | | | | | |
| M.E. CASE NO. | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) | | Halcyon Frances Littleford | | | | 2. DATE AND HOUR OF DEATH
APRIL 30, 1967 3:30 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION

00 311 Oakdale Road | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | | | | | |
| | | D. STREET ADDRESS (If rural, give location)
311 Oakdale Rd. | | | | | |
| 5. SEX
female | 6. RACE
white | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
married | 8. DATE OF BIRTH
5/16/1917 | 9. AGE (In years last birthday)
49 | If Under 1 Yr. Months: Days: Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
public school teacher | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
ontario, Canada | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Rev. Edward F. Chandler | | | 14. MOTHER'S MAIDEN NAME
Hattie Moffat | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
no | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
Rev. Osborne R. Littleford | | | |
| 18. 170 X1
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH 311 Oakdale Rd.
(A) CARCINOMATOSIS
DUE TO
(B) CARCINOMA LEFT BREAST
DUE TO
(C) | | | | INTERVAL BETWEEN ONSET AND DEATH
2 mos

3 yrs | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION
MAR. 27, 1964 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
LEFT BREAST CANCER | | 20A. AUTOPSY? (Yes or No)
NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from OCT 9 1959 to APR 30 1967 , that (I) was last saw the deceased alive on APRIL 30 1967 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) was (did) not view the body after death. | | | | | | | |
| 23A. SIGNATURE
John M. Scott | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
MAY 1, 1967 | |
| 23C. PHYSICIAN'S NAME (Type)
JOHN M. SCOTT | | | | 23D. ADDRESS
M.D. 600 N. BELVEDERE AVE, BALTIMORE, MD 21210 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Cremation | | 24B. DATE
5/3/67 | | 24C. NAME OF CEMETERY or CREMATORY
Greenmount Crematory | | 24D. LOCATION (City, town, or county) (State)
Balto. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 8 1967 | | 25B. NAME OF REGISTRAR
Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR
Mitchell-Wiedefeld Home | | ADDRESS
6500 York Rd | |
| 1967 000 4420 Balto., Md. 21212 | | | | | | | |

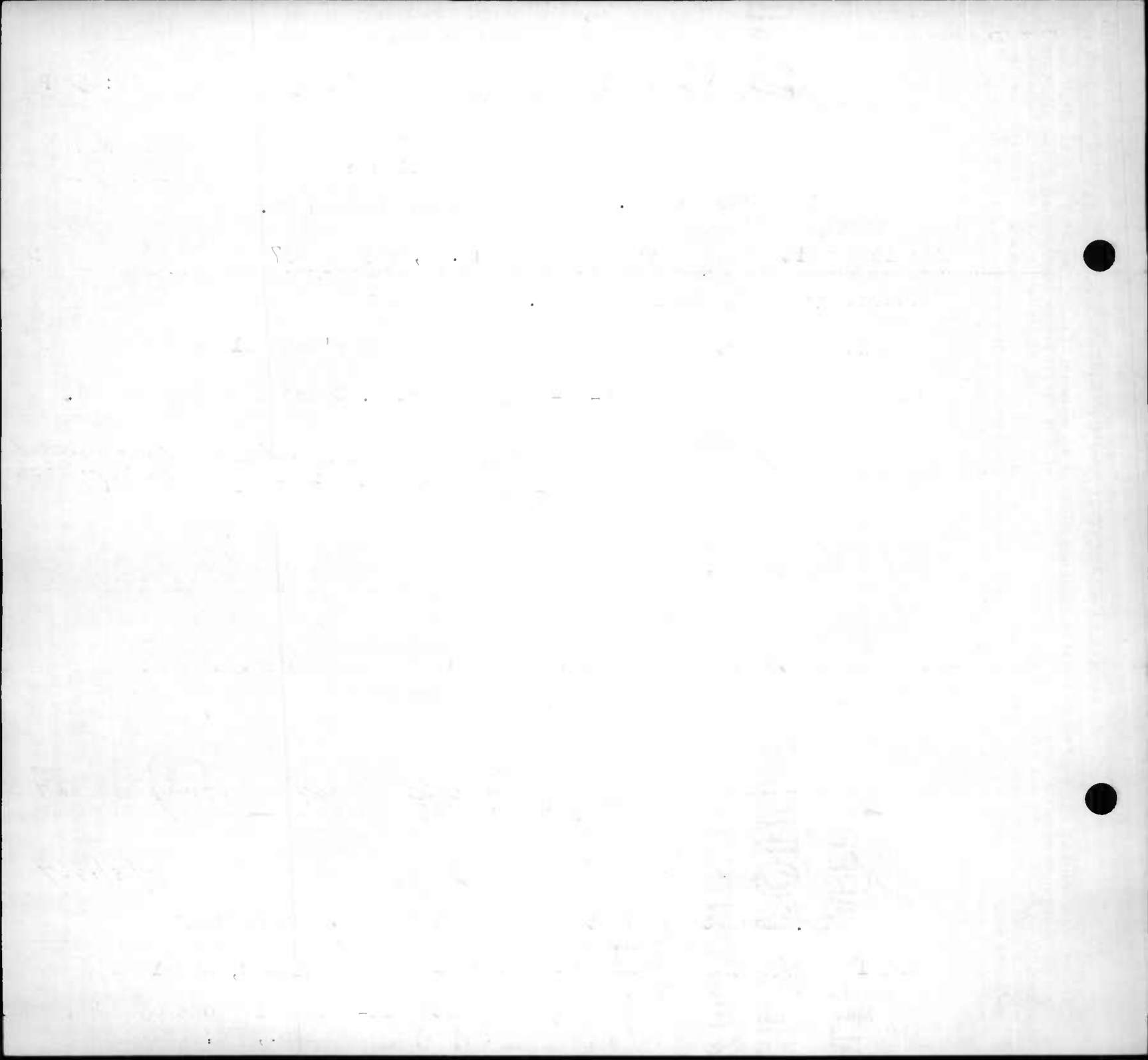
WITNESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | |
|---|-------------------------|--|--|--|---|---|-------------------------------------|---|--|--|
| CERTIFICATE OF DEATH | | | | | Registered No. 67 4421 | | | | | |
| BIRTH NO. 67 4421 | | M.E. CASE NO. | | | 1. NAME OF DECEASED
(Type or Print) AGNES VERONICA Couch | | | 2. DATE AND HOUR OF DEATH
5/3/67 12:45 P.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
1020 Woodson Rd. | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
1020 Woodson Rd. | | | | | |
| 5. SEX
female | 6. RACE
white | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
married | | 8. DATE OF BIRTH
Aug. 30, 1909 | 9. AGE (In years last birthday)
57 | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Secretary | | 10B. KIND OF BUSINESS OR INDUSTRY
Publishers Co. | | 11. BIRTHPLACE (State or foreign country)
New York | | 12. CITIZEN OF WHAT COUNTRY?
USA | | | | |
| 13. FATHER'S NAME
Pierce LaHart | | | | | 14. MOTHER'S MAIDEN NAME
Agnes O'Connell | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
no | | 16. SOCIAL SECURITY NO.
101-22-6009 | | 17. INFORMANT ADDRESS
Robert F. Couch 1020 Woodson Rd. | | | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Adenocarcinoma, colon - & generalized metastasis | | | | | INTERVAL BETWEEN ONSET AND DEATH
First diagnosed on 10/7/1966 | | | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from March 1967 to May 1967 , that (I) (we) last saw the deceased alive on May 3 (1245 P.M.) 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | |
| 23A. SIGNATURE
Robert Gebhardt M.D. | | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
5/3/1967 | | | |
| 23C. PHYSICIAN'S NAME (Type)
Dr. Robert Gebhardt | | | | | 23D. ADDRESS
1211 Northern Parkway | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
5/5/67 | | 24C. NAME of CEMETERY or CREMATORY
Baltimore National | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 8 1967 | | 25B. NAME OF REGISTRAR
Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR
Mitchell-Wiedefeld Home | | ADDRESS
6500 York Rd. Balto., Md. 21212 | | | | |

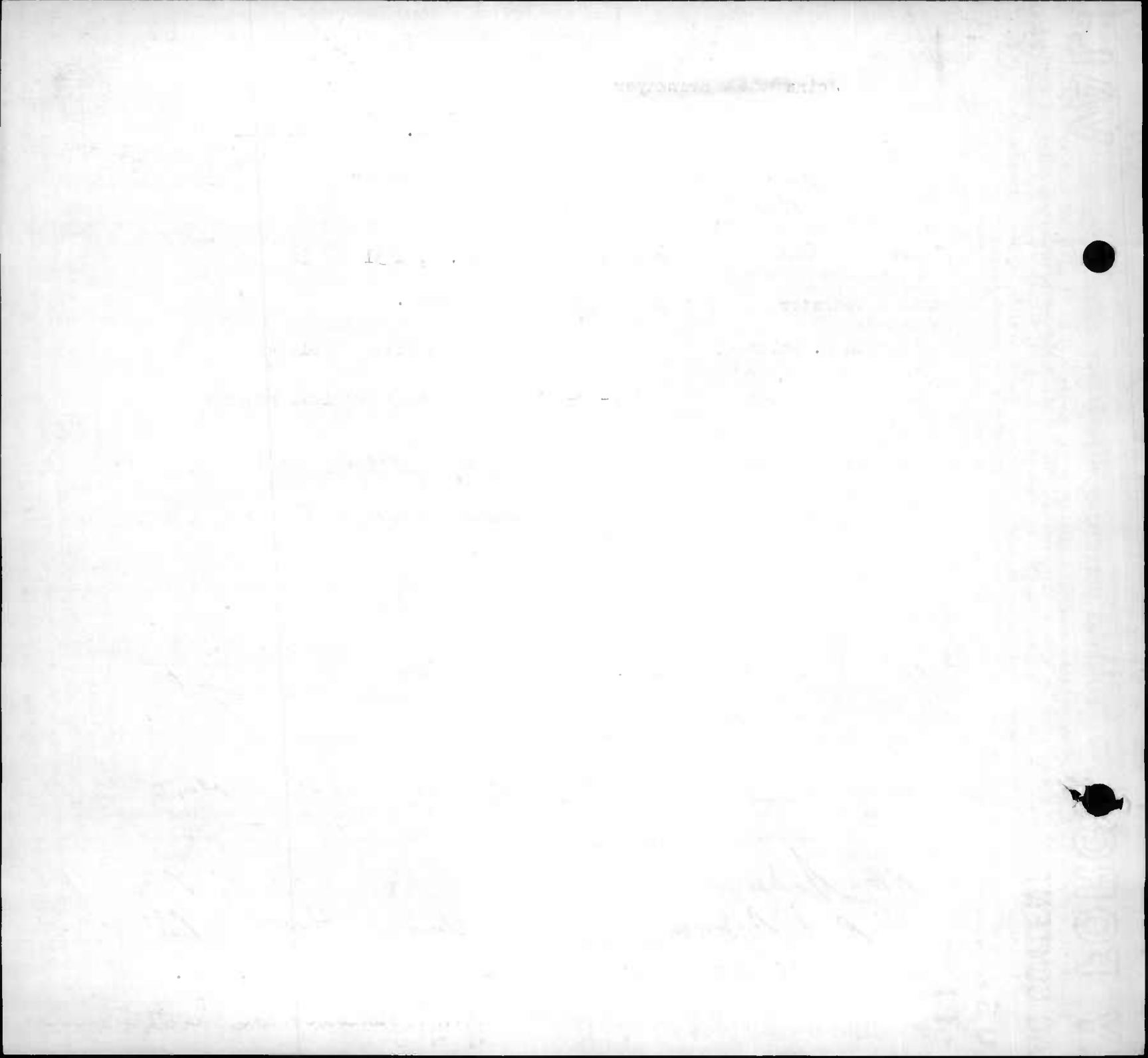


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

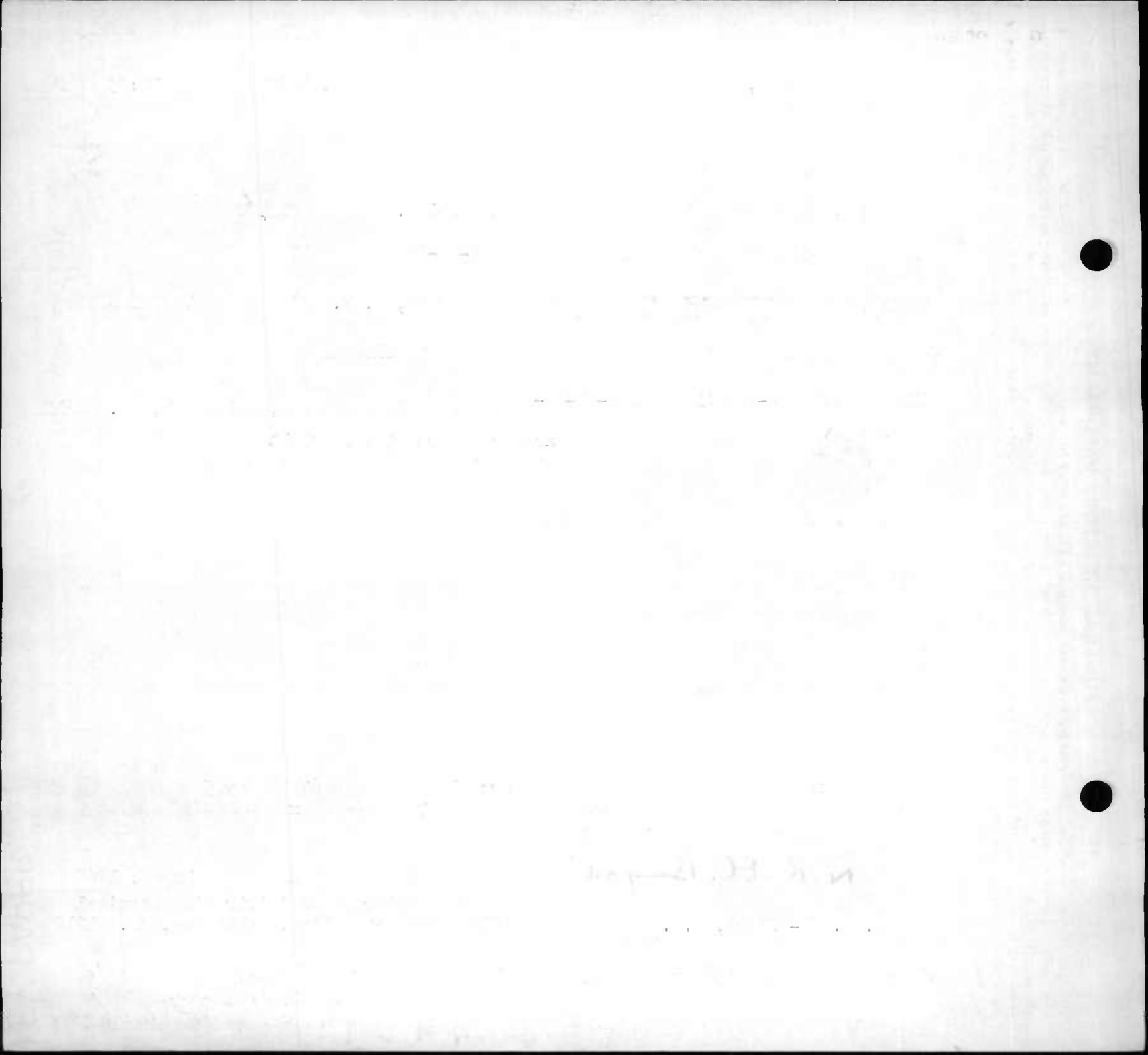
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|------------------------|--|---|--|---|---|---|--|--|
| BIRTH NO. 67 4422 | | | | | CERTIFICATE OF DEATH | | | | |
| M.E. CASE NO. | | | | | Registered No. 67 4422 | | | | |
| 1. NAME OF DECEASED
(Type or Print) Joina Brunkmyer | | | | | 2. DATE AND HOUR OF DEATH
May 3 1967 1:25 P.M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
38 University of Maryland Hospital | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Tenn. B. COUNTY Carroll | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Huntington | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location)
V-39 | | | | |
| 5. SEX
Female | 6. RACE
Cauc | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married | 8. DATE OF BIRTH
Oct. 5, 1931 | 9. AGE (In years last birthday)
36 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Machine Operator | | | 10B. KIND OF BUSINESS OR INDUSTRY
Pajama Factory | | 11. BIRTHPLACE (State or foreign country)
Tenn. | | 12. CITIZEN OF WHAT COUNTRY? | | |
| 13. FATHER'S NAME
Joseph F. Smith | | | 14. MOTHER'S MAIDEN NAME
Gertie Holiday | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No None | | | 16. SOCIAL SECURITY NO.
408-42-0526 | | 17. INFORMANT ADDRESS
University Hospital records | | | | |
| 18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Laennec's Cirrhosis with Hepatic Failure and with Esophageal Varices | | | | | INTERVAL BETWEEN ONSET AND DEATH
1-2 yrs. 5 days 1-yr. ? | | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION
April 29, 1967 | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
To relieve portal pressure | | 20A. AUTOPSY? (Yes or No)
Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
No | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
No | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from April 27 1967 to May 3 1967 , that (I) (we) last saw the deceased alive on May 3 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
R.H. Anderson | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
May 3, 1967 | | |
| 23C. PHYSICIAN'S NAME (Type)
R.H. Anderson | | | | | 23D. ADDRESS
M.D. University Hospital Baltimore Md. | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Removal | | 24B. DATE
5/5/1967 | | 24C. NAME OF CEMETERY or CREMATORY
Christian Chapel Cemetery | | 24D. LOCATION (City, town, or county) (State)
Huntingdon, Tenn. | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 8 1967 | | | 25B. NAME OF REGISTRAR
Robert E. Fagbema | | | 25C. FUNERAL DIRECTOR ADDRESS
Wm. H. Johnson & Sons Baltimore Md. | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 4423 | |
|---|-----------------------------|--|------------------------------------|--|---|
| BIRTH NO. 67 4423 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) PARTYKA, EDWARD NMN | | 2. DATE AND HOUR OF DEATH
MAY 5, 1967 10:55 P M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND B. COUNTY BALTIMORE | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
VETERANS ADMINISTRATION HOSPITAL
3900 LOCH RAVEN BOULEVARD
BALTIMORE, MARYLAND 21218 | | C. CITY OR TOWN (If outside city limits, write RURAL and give town ship)
BALTIMORE | | | |
| | | D. STREET ADDRESS (If rural, give location)
2211 E. LOMBARD STREET | | | |
| 5. SEX
MALE | 6. RACE
CAUCASIAN | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
MARRIED | 8. DATE OF BIRTH
4-25-20 | 9. AGE (In years last birthday)
47 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
WAITER | | 10B. KIND OF BUSINESS OR INDUSTRY
RESTAURANT | | 11. BIRTHPLACE (State or foreign country)
BUFFALO, N. Y. | |
| 12. CITIZEN OF WHAT COUNTRY?
UNITED STATES | | 13. FATHER'S NAME
JOSEPH PARTYKA | | 14. MOTHER'S MAIDEN NAME
ROSE MENTLEWSKI | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service)
YES 7/17/42-5/5/43 | | 16. SOCIAL SECURITY NO.
122-07-13-31 | | 17. INFORMANT
VETERANS HOSPITAL RECORDS
3900 LOCH RAVEN BLVD, BALTIMORE, MD. 21218 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)
Advanced Carcinoma of right lung with generalized metastasis | | 19. CAUSE OF DEATH
(A) DUE TO
(B) DUE TO
(C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 1 19 67 to May 5 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on May 5 19 67 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) <input checked="" type="checkbox"/> (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
N. R. El-Bayadi M.D. | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
May 5, 1967 | |
| 23C. PHYSICIAN'S NAME (Type)
N. R. EL-BAYADI, M.D. | | 23D. ADDRESS
Veterans Administration Hospital
3900 Loch Raven Blvd, Baltimore, Md. 21218 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
5-9-67 | | 24C. NAME OF CEMETERY or CREMATORY
BALTIMORE NATIONAL | |
| 24D. LOCATION (City, town, or county) (State)
BALTIMORE MD. | | 25A. DATE REC'D BY HEALTH DEPT.
MAY 8 1967 | | | |
| 25B. NAME OF REGISTRAR
Robert E. Fisher | | 25C. FUNERAL DIRECTOR
GEO. L. SCHWAB FUNERAL HOME
1740 E. Lombard St. Baltimore, Md. | | | |



1
B-550

BALTIMORE CITY HEALTH DEPARTMENT

67 4424

| BIRTH NO. 67 4424 | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. | |
|---|--|---|--|
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) HELEN E. BOWMAN | |
| 2. DATE AND HOUR PRONOUNCED DEAD
May 5, 1967 5:30 A.M. | | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
00 303 N. Gilmore Street | |
| 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE Maryland
B. COUNTY Baltimore | | 5. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore | |
| 6. STREET ADDRESS (If rural, give location)
303 N. Gilmore Street | | 7. SEX Female | |
| 8. RACE Negro | | 9. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOW | |
| 10. DATE OF BIRTH Oct. 25, 1919 | | 11. AGE (In years last birthday) 47 | |
| 12. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DOMESTIC | | 13. KIND OF BUSINESS OR INDUSTRY POT FAMILY | |
| 14. BIRTHPLACE (State or foreign country) BALTO MD | | 15. CITIZEN OF WHAT COUNTRY? USA | |
| 16. FATHER'S NAME CHARLES ROBERTS | | 17. MOTHER'S MAIDEN NAME MARTHA ANDERSON | |
| 18. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 19. SOCIAL SECURITY NO. | |
| 20. INFORMANT ADDRESS MARTHA ROBERTS 1414 WARD ST | | 21. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
157X I
CAUSE OF DEATH
(A) Carcinoma of head of pancreas
DUE TO
(B)
DUE TO
(C) | |
| 22. DATE OF OPERATION 0 | | 23. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 24. AUTOPSY? (Yes or No) No | | 25. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 26. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 27. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 28. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 29. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Min.) | |
| 30. INJURY OCCURRED WHILE AT WORK [] NOT WHILE AT WORK [] | | 31. HOW DID INJURY OCCUR? | |
| 32. I certify that I held an Inquiry [] Inspection [X] Autopsy [] and that on this basis, death in my opinion resulted from: Natural causes [X] Accident [] Suicide [] Homicide [] Undetermined manner [] | | | |
| 33. ACTUAL SIGNATURE Charles S. Springate, M.D. | | 34. CHIEF MEDICAL EXAMINER [] DATE SIGNED May 5, 1967 | |
| 35. EXAMINER'S NAME (Type) Charles S. Springate, M.D. | | 36. ASSISTANT MEDICAL EXAMINER [X] | |
| 37. ASSOCIATE MEDICAL EXAMINER [] | | 38. NAME OF CEMETERY or CREMATORY Mt AUBURN | |
| 39. BURIAL CREMATION, REMOVAL (Specify) Burial | | 40. DATE 5/9/67 | |
| 41. LOCATION (City, town, or county) BALTO MD | | 42. STATE | |
| 43. DATE REC'D BY HEALTH DEPT. MAY 8 1967 | | 44. NAME OF REGISTRAR R. E. Fawcett | |
| 45. FUNERAL DIRECTOR Margaret P. Hays | | 46. ADDRESS 638 N. Gilmore ST | |

19670004432

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|--|--|--|---|--|
| BIRTH NO. 67 4425 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 4425 | |
| M.E. CASE NO. SPARROW JENNIE | | | 2. DATE AND HOUR OF DEATH May 7, 1967 8:00 P.M. | | |
| 1. NAME OF DECEASED (Type or Print) Sparrow Jennie | | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE B. COUNTY | | |
| THE JOHNS HOPKINS HOSPITAL 33 | | | MARYLAND | | |
| 5. SEX FEMALE 6. RACE NEGRO 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOW | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | |
| 8. DATE OF BIRTH 5-15-24 9. AGE (In years lost birthday) 42 | | | D. STREET ADDRESS (If rural, give location) 513 EDGEWOOD ST. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DOMESTIC | | | 11. BIRTHPLACE (State or foreign country) BALTIMORE MD | | |
| 10B. KIND OF BUSINESS OR INDUSTRY Put Family | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME WILLIAM PARKER | | | 14. MOTHER'S MAIDEN NAME MAMIE THOMPSON | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | 16. SOCIAL SECURITY NO. 218-18-4891 | | |
| 17. INFORMANT MAMIE PATERSON | | | ADDRESS 513 Edgewood St | | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| (A) Cardiac Arrest | | | 4 hrs 15 min | | |
| (B) Pulmonary Edema | | | 4 hrs | | |
| (C) Myocardial Failure | | | 4 days | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Bilateral Bronchial Pneumonia | | | | | |
| 19A. DATE OF OPERATION 7-28-67 | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Mitral and Aortic Stenosis | | |
| 20A. AUTOPSY? (Yes or No) NO | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | |
| 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on May 4, 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE A. A. Maresse M.D. | | | 23B. DATE SIGNED 5-4-67 | | |
| 23C. PHYSICIAN'S NAME (Type) A. MARESSE | | | 23D. ADDRESS THE JOHNS HOPKINS HOSPITAL | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 5/8/67 | | 24C. NAME OF CEMETERY OR CREMATORY BALTO NATIONAL | |
| 24D. LOCATION BALTO MD | | 24E. DATE REC'D BY HEALTH DEPT. MAY 8 1967 | | 24F. NAME OF REGISTRAR Robert E. Farley | |
| 24G. FUNERAL DIRECTOR | | 24H. ADDRESS | | 24I. DATE SIGNED | |
| Manhattan P. Hayes | | 638 N. Gilmor St | | | |

PAVON, J. L. 1993. 25

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 4426 | |
|---|--|--|--|--|--|
| BIRTH NO. 67 4426 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) James Joseph Williams | | | |
| 2. DATE AND HOUR OF DEATH
2 May 67 | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND
University of Maryland Hospital
<small>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)</small> | | | |
| 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY Baltimore City | | 5. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | | | |
| 6. STREET ADDRESS (If rural, give location)
8 East Montgomery Street | | 7. SEX M RACE N | | | |
| 8. DATE OF BIRTH 5-5-15 | | 9. AGE (In years last birthday) 52 | | 10. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
married (sep.) | |
| 11. BIRTHPLACE (State or foreign country)
Washington, D. C. | | 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
George Williams | |
| 14. MOTHER'S MAIDEN NAME
Rose Ann Windborn | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes or No, Unknown) (If yes, give war or dates of service)
Unknown | | 16. SOCIAL SECURITY NO.
219 01 7601 | |
| 17. INFORMANT
Patient's chart | | ADDRESS | | | |
| 18. CAUSE OF DEATH
572 X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Uraemia
(A) DUE TO
Chronic Renal Disease
(B) DUE TO
(C) DUE TO | | | | INTERVAL BETWEEN ONSET AND DEATH
1 month +
1 year + | |
| II
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 26 April 19 67 to 2 May 19 67 , that (I) (we) last saw the deceased alive on 2 May 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
S. Stapleton, Jr.
M.D. | | | | 23B. DATE SIGNED
2 May 1967 | |
| 23C. PHYSICIAN'S NAME (Type)
Sidney L. Stapleton, Jr.
M.O. | | | | 23D. ADDRESS
University of Maryland Hospital | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
5-6-67 | | 24C. NAME OF CEMETERY or CREMATORY
Mount Auburn | |
| 24D. LOCATION (City, town, or county) (State)
Baltimore-City | | 25A. DATE REC'D BY HEALTH DEPT.
MAY 8 1967 | | | |
| 25B. NAME OF REGISTRAR
Robert E. Farley, M.D. | | 25C. FUNERAL DIRECTOR
Isaiah L. Brown and Son
100 W Montgomery Street | | | |

10-10-41

TO :

FROM :

SUBJECT :

RE :

DATE :

TIME :

PLACE :

BY :

+ 10000

+ 10000

TO :

FROM :

SUBJECT :

RE :

DATE :

TIME :

PLACE :

BY :

10-10-41

10-10-41

10-10-41

10-10-41

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 4427 | |
|---|-------------------------|--|---|--|---|
| <div style="display: flex; justify-content: space-between;"> BIRTH NO. 67 4427 CERTIFICATE OF DEATH </div> | | | | | |
| <div style="display: flex; justify-content: space-between;"> M.E. CASE NO. John F. Dornick 2. DATE AND HOUR OF DEATH
5-5-67 4:10 P.M. </div> | | | | | |
| <div style="display: flex; justify-content: space-between;"> 1. NAME OF DECEASED
(Type or Print) John F. Dornick </div> | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

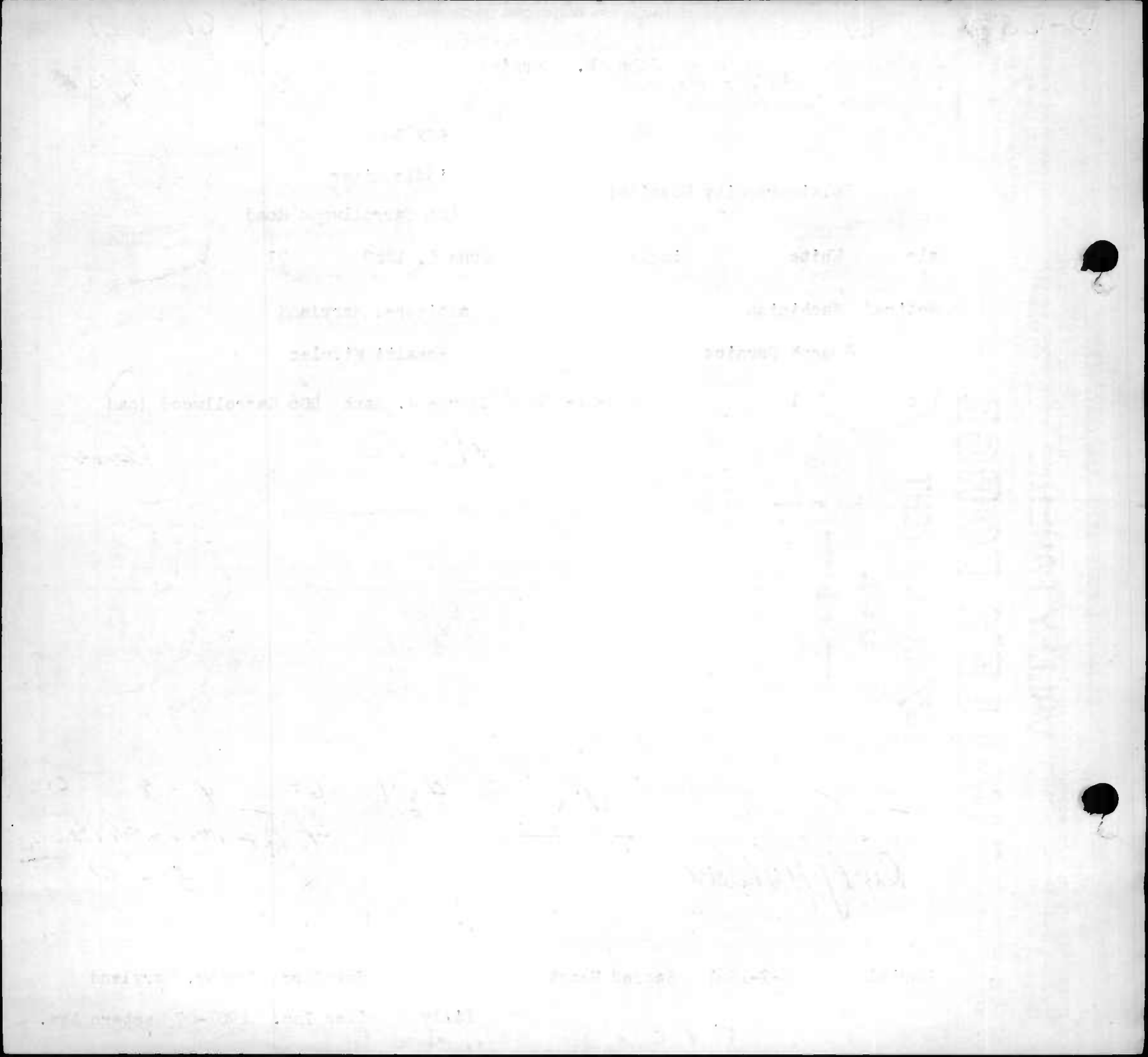
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Baltimore City Hospital | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE Maryland
B. COUNTY Baltimore Co.
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Middle River
D. STREET ADDRESS (If rural, give location)
406 Carrollwood Road | | |
| 5. SEX
Male | 6. RACE
White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
Single | 8. DATE OF BIRTH
June 1, 1889 | 9. AGE (In years last birthday)
77 | If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired Machinist | | | 10B. KIND OF BUSINESS OR INDUSTRY
Baltimore, Maryland | | 11. BIRTHPLACE (State or foreign country)
Baltimore, Maryland |
| 13. FATHER'S NAME
Joseph Dornick | | | 14. MOTHER'S MAIDEN NAME
Rosalie Mikulec | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
Yes WW I | | | 16. SOCIAL SECURITY NO.
213-01-5324 | | 17. INFORMANT ADDRESS
George J. Rauh 406 Carrollwood Road |
| <div style="display: flex; justify-content: space-between;"> <div> 18. 422.1 I
 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
 (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)

 ANTECEDENT CAUSES
 DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. </div> <div> CAUSE OF DEATH
 ASCVD
 (A) DUE TO

 (B) DUE TO

 (C) </div> <div> INTERVAL BETWEEN ONSET AND DEATH
 Years </div> </div> | | | | | |
| <div style="display: flex; justify-content: space-between;"> <div> II
 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. </div> </div> | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 4-4-65 to 4-9-65 , that (I) (we) last saw the deceased alive on 4-9-65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. At D.O.A. signed by Medical Examiner | | | | | |
| 23A. SIGNATURE
Raul M. Mikulec | | | | 23B. DATE SIGNED
5-6-67 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
5-9-1967 | | 24C. NAME of CEMETERY or CREMATORY
Sacred Heart | |
| 24D. LOCATION (City, town, or county) (State)
Baltimore County, Maryland | | 25A. DATE REC'D BY HEALTH DEPT.
MAY 8 1967 | | | |
| 25B. NAME OF REGISTRAR
Robert E. Sweeney | | 25C. FUNERAL DIRECTOR ADDRESS
Lilly & Zeiler Inc. 1901-07 Eastern Ave. | | | |



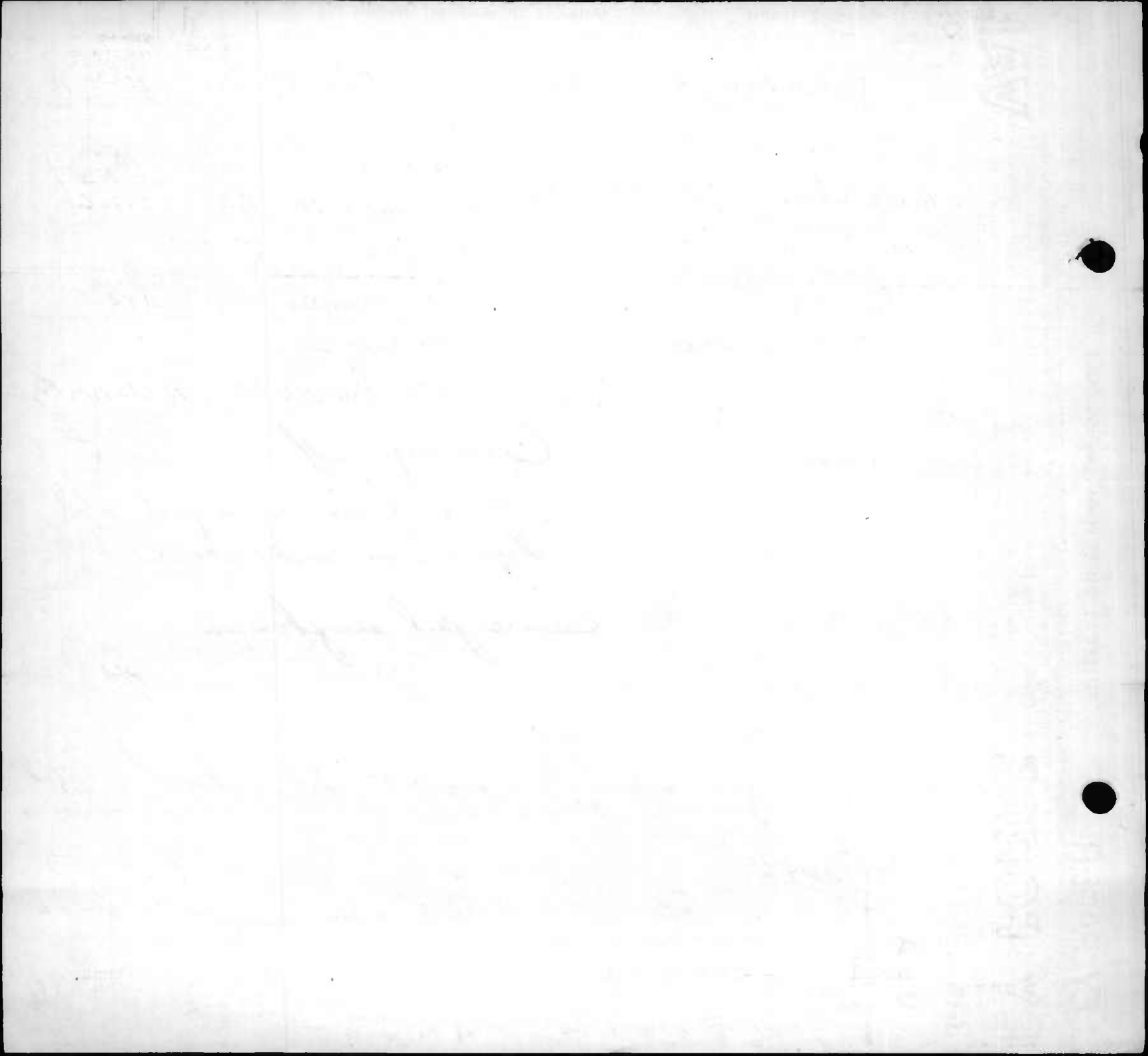
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|---------------|---|--|--|--|---|-------------------------------------|--|--|
| CERTIFICATE OF DEATH | | | | | Registered No. 67 4428 | | | | |
| BIRTH NO. 67 4428 | | | | | | | | | |
| M.E. CASE NO. | | | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) FREDERICK K. HIRSH | | | | | 2. DATE AND HOUR OF DEATH
5/4/67 1150 P M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location)
49 NORTH CHARLES GEN. HOSPITAL | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE 27-34 | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location)
4111 GLENARM AVE 21206 | | | | |
| 5. SEX
M. | 6. RACE
W. | 7. (MARRIED) NEVER MARRIED
WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH
2/19/02 | 9. AGE (In years last birthday)
65 | If Under 1 Yr. Months: Days: | | If Under 24 Hrs. Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired | | | 10B. KIND OF BUSINESS OR INDUSTRY
Eastern Overall Co. | | 11. BIRTHPLACE (State or foreign country)
Pa Pottsville | | 12. CITIZEN OF WHAT COUNTRY?
USA | | |
| 13. FATHER'S NAME
Nicholas Hirsch | | | 14. MOTHER'S MAIDEN NAME
ELIZABETH | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | 16. SOCIAL SECURITY NO.
2-7-05-7513 | | 17. INFORMANT
ROBERT ROSENBERG, N. Charles Hgpt. | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH
(A) DUE TO
Coronary insuff
(B) DUE TO
atherosclerosis, coronary art. old
(C) DUE TO
Hypertensive cardio vas dis | | | INTERVAL BETWEEN ONSET AND DEATH
Recent | | | |
| | | | II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Severe pul. embolism | | | | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
Yes | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from May 4th 1967 to May 4th 1967, that (I) (we) lost saw the deceased alive on May 4th 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
C. E. Campbell | | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
5-5-67 | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | | 23D. ADDRESS
M.D. 5428 Findlay Lane Balto 21206 | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
5-9-1967 | | 24C. NAME OF CEMETERY or CREMATORY
Oddfellow Cemetery | | 24D. LOCATION (City, town, or county) (State)
St. Clair Penna. | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 8 1967 | | 25B. NAME OF REGISTRAR
Robert E. Taylor | | 25C. FUNERAL DIRECTOR
L. Home 7401 Belair Rd | | 25D. ADDRESS (City, town, or county) (State)
Baltimore Md. | | | |



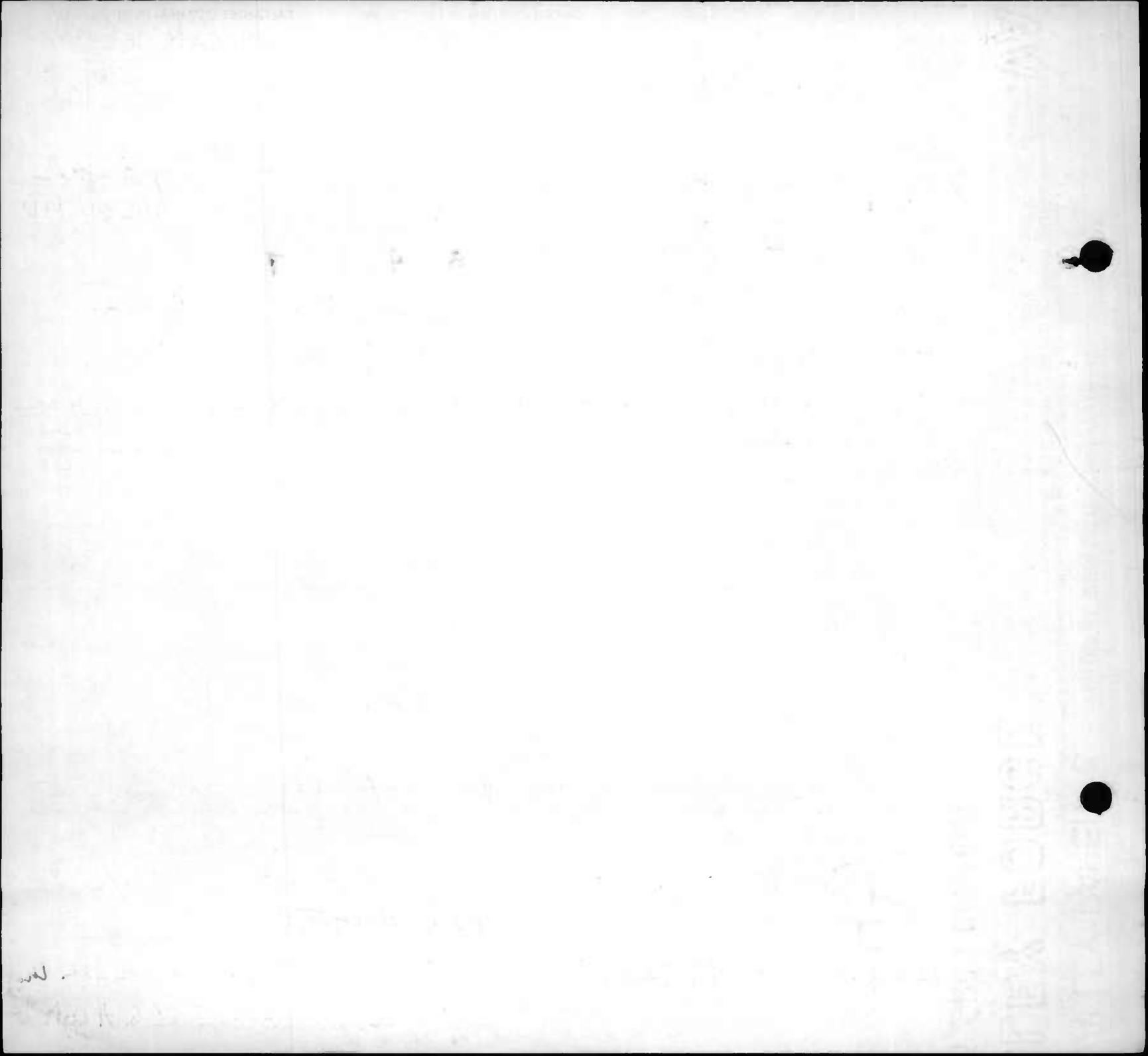
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 4429 | |
|--|---------------------|---|--|---|---|
| BIRTH NO. 67 4429 | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED
(Type or Print) VINCENT JESTER | | | 2. DATE AND HOUR OF DEATH
5/4/67 1:30 P.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
37 MERCY HOSPITAL | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE _____ B. COUNTY _____

C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE 3-02
D. STREET ADDRESS (If rural, give location)
945 E. BALTO. ST. BALTO., MD. | | |
| 5. SEX
W | 6. RACE
M | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
SINGLE | 8. DATE OF BIRTH
9/8/99 | 9. AGE (In years last birthday)
67 | 10. CITIZEN OF WHAT COUNTRY?
U.S.A. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
RETIRED | | | 10B. KIND OF BUSINESS OR INDUSTRY
Beamster | | |
| 11. BIRTHPLACE (State or foreign country)
Baltimore Md. | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | |
| 13. FATHER'S NAME
Anthony Jester | | | 14. MOTHER'S MAIDEN NAME
Maggie Walton | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
yes W.W.I | | | 16. SOCIAL SECURITY NO.
218-05-6451 | | |
| 17. INFORMANT
Mr. Walter Jester | | | ADDRESS
4213 Sommers Ave | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
Bronchogenic Ca | | | CAUSE OF DEATH
(A) DUE TO
Widespread metastasis | | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Pneumonia & Atelectasis | | | INTERVAL BETWEEN ONSET AND DEATH
4 mos. - yrs. | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
— | | 20A. AUTOPSY? (Yes or No)
yes | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
yes | | 21. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 5/25/67 19 67 to 5/5 19 67 , that (I) (we) last saw the deceased alive on 5/4 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
North N. Foster | | | 23B. DATE SIGNED
5/5/67 | | |
| 23C. PHYSICIAN'S NAME (Type)
M.D. | | | 23D. ADDRESS
Mercy Hospital | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
5-8-67 | | 24C. NAME OF CEMETERY or CREMATORY
Baltimore National Cem. 5501 Frederick Ave and | |
| 24D. LOCATION (City, town, or county) (State)
Baltimore | | 25A. DATE REC'D BY HEALTH DEPT.
MAY 8 1967 | | | |
| 25B. NAME OF REGISTRAR
Robert E. Taylor | | 25C. FUNERAL DIRECTOR
Joseph D. Bellamore | | | |
| ADDRESS
322 S. High St | | | | | |



BIRTH NO.

67 4430

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 4430

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

EUGENE T. GROSS

2. DATE AND HOUR PRONOUNCED DEAD

May 5, 1967 1:30 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

48 Maryland General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

448 Walton Court

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Single

8. DATE OF BIRTH

3-15-1932

9. AGE (In years
last birthday)

35

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Maintenance

10B. KIND OF BUSINESS OR INDUSTRY

G.S.A.

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Wendel Gross

14. MOTHER'S MAIDEN NAME

Margaret G. Adams

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

WW II

16. SOCIAL
SECURITY NO.

219-28-5349

17. INFORMANT

Annie Gross - 448 Walton Court

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Lobar Pneumonia.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Petty

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

5/6/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

5-9-67

23C. NAME OF CEMETERY or CREMATORY

Baltimore National

23D. LOCATION (City, town, or county)

Baltimore, Maryland

(State)

24A. DATE REC'D BY HEALTH DEPT.

MAY 8 1967

24B. NAME OF REGISTRAR

Robert E. Fairbanks

24C. FUNERAL DIRECTOR

Charles R. Law 802 Madison Ave.

ADDRESS

WALLACE FORGE

MILK FARM

WYOMING

Charles W. Wallace

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 4431 | |
|---|-------------------------|--|-------------------------------------|--|--|
| BIRTH NO. 67 4431 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) Burns, Amanda J. | | | |
| 2. DATE AND HOUR OF DEATH
5-2-67 11:15 A.M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
Belton Hill Nursing Home | | A. STATE MD. B. COUNTY Harford | | | |
| (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | | | |
| | | D. STREET ADDRESS (If rural, give location)
704 Elster Hall Rd. | | | |
| 5. SEX
Female | 6. RACE
White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
Widowed | 8. DATE OF BIRTH
3-4-1882 | 9. AGE (In years last birthday)
85 | 10. CITIZEN OF WHAT COUNTRY?
USA |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY
Own Home | | 11. BIRTHPLACE (State or foreign country)
Pennsylvania | |
| 13. FATHER'S NAME
Miller, John | | 14. MOTHER'S MAIDEN NAME
Holtzapple, Mary | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT
Family | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
150XVI-260X | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | (A) tumor of esophagus | | several mos. | |
| ANTECEDENT CAUSES | | (B) probable malignancy | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) | | | |
| II | | DIABETES MELLITUS | | several mos. | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | A.S.C.V.D. | | several yrs. | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 4-17-67 19 to 5-2-67 19, that (I) (we) last saw the deceased alive on 5-1-67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
E. Ellsworth Cook M.D. | | | | 23B. DATE SIGNED
5-2-67 | |
| 23C. PHYSICIAN'S NAME (Type)
E. ELLSWORTH COOK | | | | 23D. ADDRESS
2431 Maryland Ave. Balto. 21218 Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
May 5 1967 | | 24C. NAME of CEMETERY or CREMATORY
Saters Cemetery | |
| 24D. LOCATION (City, town, or county) (Stotel)
Lutherville, Md. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 8 1967 | | 25B. NAME OF REGISTRAR
Robert E. Fink | | 25C. FUNERAL DIRECTOR
John Burns | |
| | | | | ADDRESS
Anne Towson, Md. | |

F. B. Smith

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 67 4432

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

WINNIFRED DOLAN

2. DATE AND HOUR OF DEATH

5/4/67

6:00 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)31 BOLT. CITY. HOSP.
4940 Eastern Ave. Baltimore, Md. #212244. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE B. COUNTY

MD

Baltimore Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

BALTIMORE

53-00

D. STREET ADDRESS (If rural, give location)

8 113 SUMTER AVE

21206

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED

WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

12/28/10

9. AGE (In years
last birthday)

56

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Pa.

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

FRED BOWERS

14. MOTHER'S MAIDEN NAME

LAURA Michel

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

217 220 150

17. INFORMANT

ADDRESS

#21224

BCH: Records 4940 Eastern Ave. Baltimore, Md.

18. 420.1 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) MYOCARDIAL INFARCT
DUE TO

15 DAYS

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.(B) _____
DUE TO

(C) _____

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

White At
Work ☐Not White
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (1) (this hospital) attended the deceased from 4/20/1967 to 5/4/1967,
that (I) (we) last saw the deceased alive on 5/3/1967 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

P. J. McLEOD

M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

5/4/67

23C. PHYSICIAN'S
NAME (Type)

P. J. McLEOD

M.D.

23D. ADDRESS

4940 Eastern Ave. Baltimore, Maryland #21224
BOLT. CITY HOSP.24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

5/8/67

24C. NAME OF CEMETERY or CREMATORY

Oak Lawn Cemetery

24D. LOCATION

(City, town, or county)

Baltimore Md.

(State)

25A. DATE REC'D BY HEALTH DEPT.

MAY 8 1967

25B. NAME OF REGISTRAR

Robert E. Fadden

25C. FUNERAL DIRECTOR

Philip E. Chas

ADDRESS

1211 Chesaco Ave.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BOULDER CITY, NEV.

FRANK BOWERS

2112 11 3

1212 11 3

12

1212

1212 11 3

1212 11 3

12

1212

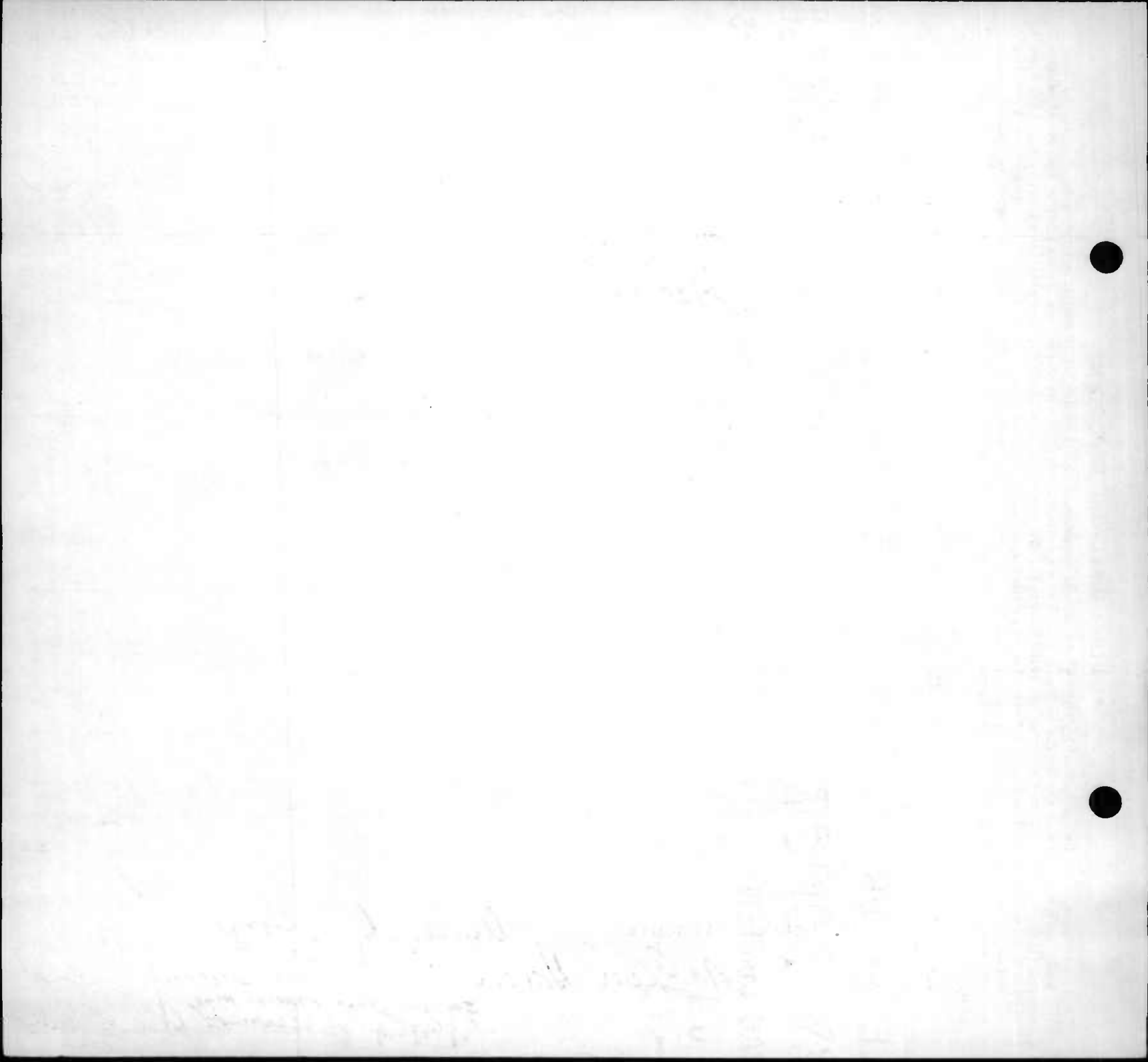
BOULDER CITY, NEV.

BOULDER CITY, NEV.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

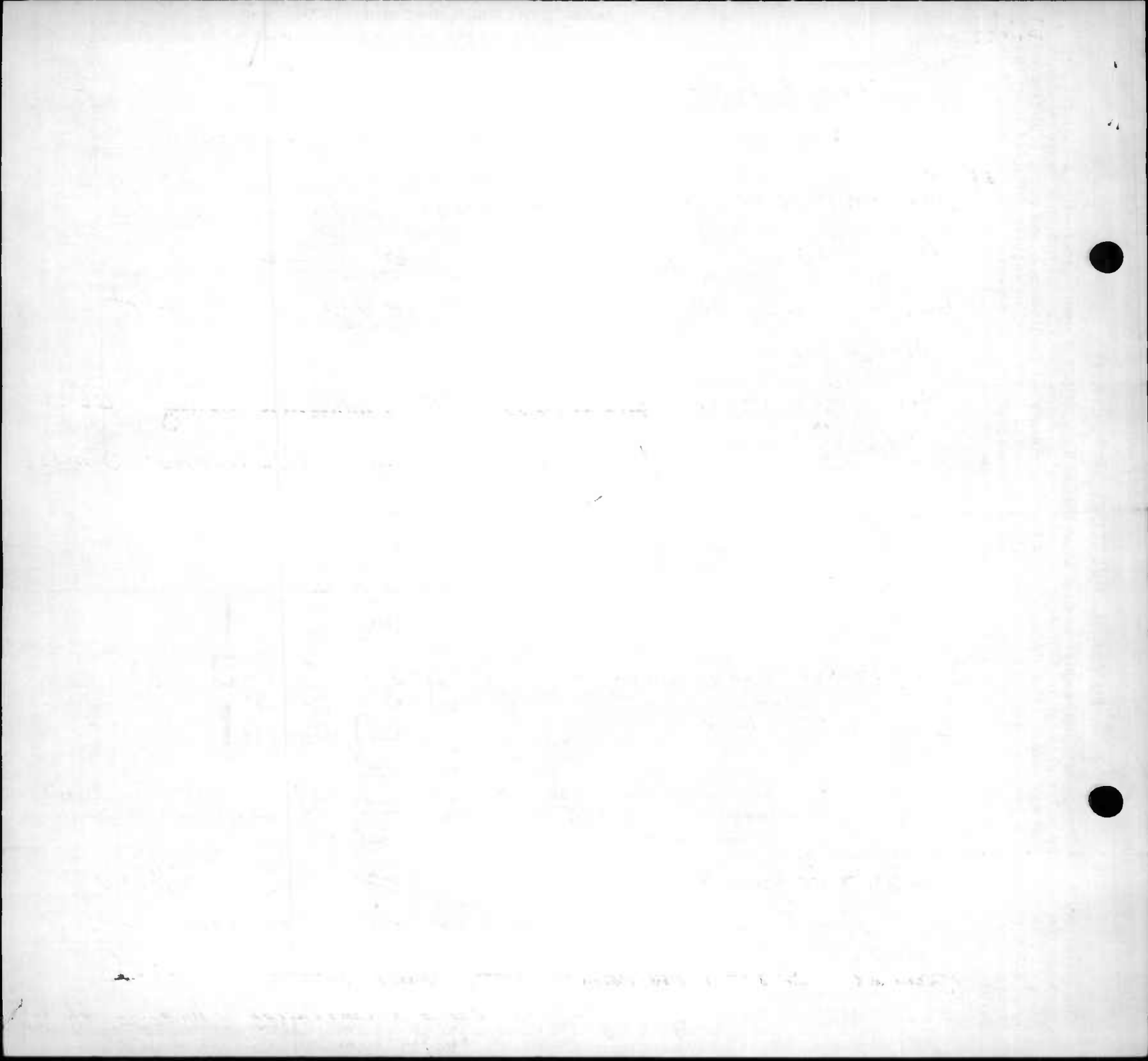
| | | | | | | | |
|---|---------------------|--|---|--|---|---|--|
| B-600 | | BIRTH NO. 67 4433 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 4433 | |
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) <u>BOYER, BERNARD H.</u> | | | | 2. DATE AND HOUR OF DEATH
<u>5/3/67</u> <u>1:30</u> P. M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>38 UNIV. HOSP.</u> | | | | A. STATE <u>MD</u> B. COUNTY <u>BALT</u> C. CITY OR TOWN <u>A.G.C.</u> | | | |
| (If not in hospital or institution, give street address or location) | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>ARNOLD, MD 52-00</u> | | | |
| | | | | D. STREET ADDRESS (If rural, give location)
<u>RT# 808 BUENA VISTA AVE</u> | | | |
| 5. SEX
<u>M</u> | 6. RACE
<u>W</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)
<u>Married</u> | 8. DATE OF BIRTH
<u>2/23/36</u> | 9. AGE (In years last birthday)
<u>31</u> | If Under 1 Yr. Months: Days: Hours: Min. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>ST RD INSPECTOR</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>ST RD INSPECTOR</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>ST RD</u> | | 11. BIRTHPLACE (State or foreign country)
<u>USA - Md.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> |
| 13. FATHER'S NAME
<u>FRANK J BOYER</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>VIRGINIA HIRSH</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>yes 1959-1967</u> | | | | 16. SOCIAL SECURITY NO.
<u>?</u> | | 17. INFORMANT
<u>Maria Boyer - Elmore</u> | |
| 18. <u>20431</u> | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | (A) <u>HEMORRHAGE - INT.</u>
DUE TO | | <u>IRS</u> | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) <u>ACUTE LEUKEMIA</u>
DUE TO | | <u>?</u> | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | (C) | | | |
| 19A. DATE OF OPERATION
<u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<u>N.O</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>4/10/67</u> 19 to <u>5/3/67</u> 19, that (I) (we) last saw the deceased alive on <u>5/3/67</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
<u>H. Loudon Kiracofe</u> M.D. | | | | 23B. DATE SIGNED
<u>5/3/67</u> | | | |
| 23C. PHYSICIAN'S NAME (Type)
<u>H. Loudon Kiracofe</u> | | | | 23D. ADDRESS
<u>University Hosp.</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>5-6-67</u> | | 24C. NAME OF CEMETERY OR CREMATORY
<u>Glen Haven Cem.</u> | | 24D. LOCATION (City, town, or county) (State)
<u>Glen Burnie Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>MAY 8 1967</u> | | 25B. NAME OF REGISTRAR
<u>Robert E. Jackson</u> | | 25C. FUNERAL DIRECTOR
<u>SAVANA PARK FUNERAL HOME</u> | | ADDRESS
<u>1401 E. ...</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

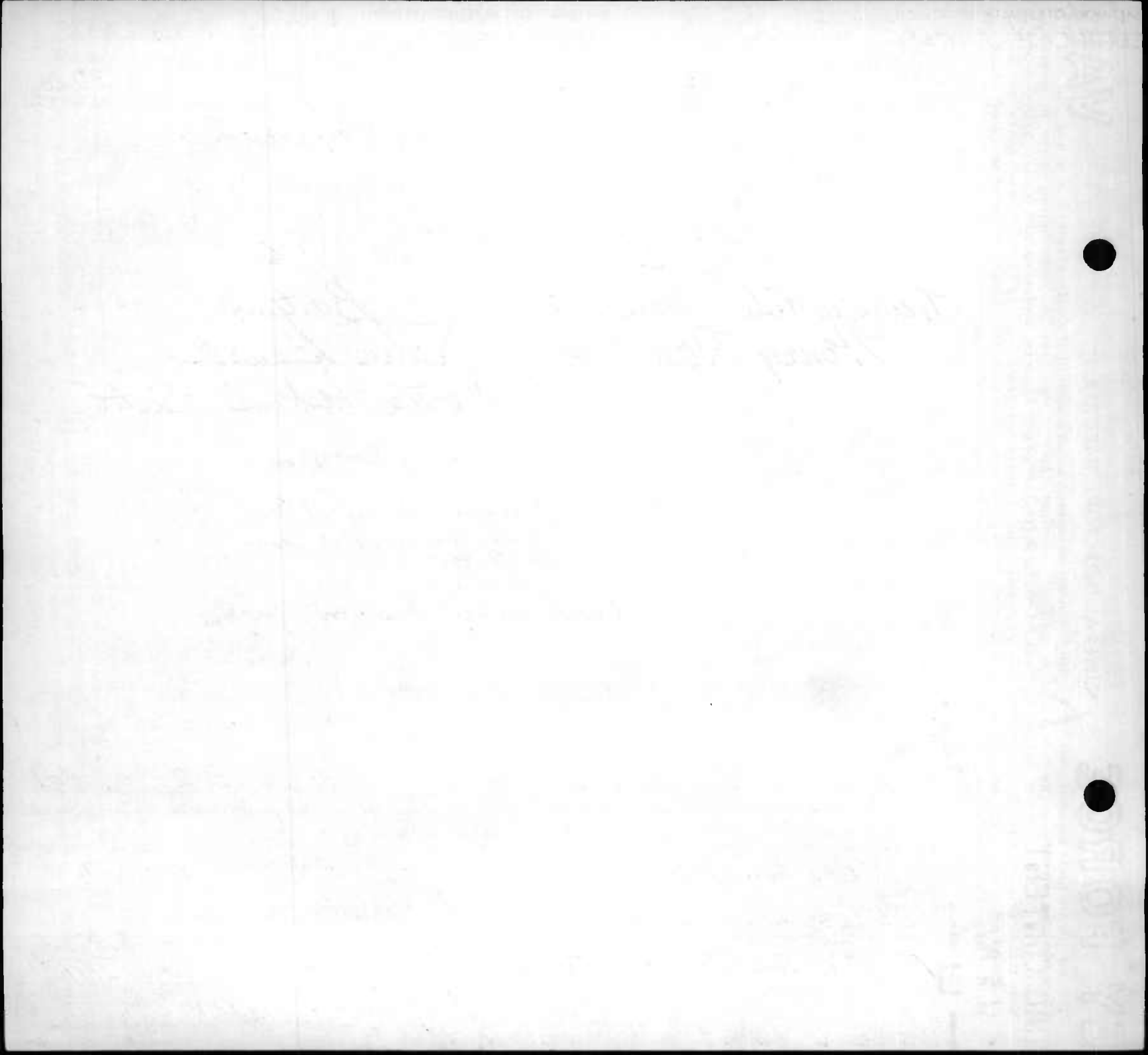
| | | | | | |
|--|--|---|--|--|--|
| BIRTH NO. 67 4434 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 4434 | |
| M.E. CASE NO. | | | 2. DATE AND HOUR OF DEATH | | |
| 1. NAME OF DECEASED
(Type or Print) IRVIN F. LONG | | | 5/5/67 5:40 A.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
Sinai Hospital of Baltimore, Inc. | | | A. STATE MD. B. COUNTY Anne Arundel Co. | | |
| (If not in hospital or institution, give street address or location) | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
GLENBURNIE 52-00 | | |
| | | | D. STREET ADDRESS (If rural, give location)
8924 TWIN RIDGE DR. | | |
| 5. SEX
M | 6. RACE
CAU. | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
M | 8. DATE OF BIRTH
8/13/24 | 9. AGE (In years last birthday)
42 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
QUALITY CONTROL | | 10B. KIND OF BUSINESS OR INDUSTRY
U.S. Gov't. | 11. BIRTHPLACE (State or foreign country)
MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
USA |
| 13. FATHER'S NAME
ARTHUR LONG | | | 14. MOTHER'S MAIDEN NAME
UNK. | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
Yes 1943-1946 | | 16. SOCIAL SECURITY NO.
212 200633 | 17. INFORMANT ADDRESS
WIFE Catherine Long 4000 | | |
| 18. 193.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
CAUSE OF DEATH
(A) Glioblastoma MULTIFORME 5 mos. | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (B) DUE TO | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | (C) DUE TO | | |
| 19A. DATE OF OPERATION
Dec. 23, 1966 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
BRAIN Tumor | 20A. AUTOPSY? (Yes or No)
Yes | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
None | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
- | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)
- | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?
- | | |
| 22. I certify that (I) (this hospital) attended the deceased from 4/3 1967 to 5/5 1967, that (I) (we) lost saw the deceased alive on 5/5 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
J. Brett Lazar, M.D. | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | 23B. DATE SIGNED
5/5/67 | |
| 23C. PHYSICIAN'S NAME (Type)
J. BRETT LAZAR | | | 23D. ADDRESS
M.D. SINAI HOSP. OF BALTIMORE, INC. | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | 24B. DATE
5-8-67 | 24C. NAME OF CEMETERY or CREMATORY
Glenbury Park Cem. | 24D. LOCATION (City, town, or county) (State)
Baltimore Md. | | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 8 1967 | 25B. NAME OF REGISTRAR
Robert E. Barranco | 25C. FUNERAL DIRECTOR
Robert S. Barranco | | ADDRESS
Severna Pk. Md. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|------------|--|--|--|---|
| BIRTH NO. 67 4435 | | CITY HEALTH DEPARTMENT | | Registered No. 67 4435 | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED
(Type or Print) DANKSBY ALICE R. | | | 2. DATE AND HOUR OF DEATH
5.2.67 11.50 a.m. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
46 Dufferin Hospital of Md. | | | A. STATE Maryland
B. COUNTY Baltimore
C. CITY OR TOWN Baltimore
D. STREET ADDRESS (If rural, give location) 1301 N. Montford Ave. | | |
| 5. SEX F. | 6. RACE N. | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Sep | 8. DATE OF BIRTH 5.11.1910 | 9. AGE (In years last birthday) 56 | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse aide | | 10B. KIND OF BUSINESS OR INDUSTRY Hospital | | 11. BIRTHPLACE (State or foreign country) MD Baltimore | |
| 13. FATHER'S NAME Henry Rose dom. | | | 14. MOTHER'S MAIDEN NAME Julia Beard | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Bertha Haskens Sister |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
463X Pulmonary Embolism | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II Cerebrovascular Accident, Thrombosis | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 4.15 19 67 to 5.2 19 67, that (I) (we) last saw the deceased alive on 5.2 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Atlas Radejkhov | | | | 23B. DATE SIGNED 5.2.67 | |
| 23C. PHYSICIAN'S NAME (Type) MILOŠ RADOJKOVIC | | | | 23D. ADDRESS Dufferin Hospital. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 5-6-67 | | 24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Balto | |
| 24D. LOCATION (City, town, or county) Md | | 25A. DATE REG'D BY HEALTH DEPT. MAY 8 1967 | | | |
| 25B. NAME OF REGISTRAR Robert E. Fairman | | 25C. FUNERAL DIRECTOR ADDRESS Rayner Sanders 217 E. Preston St | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 4436 | |
|---|-----------------------|---|-------------------------------------|--|--|
| BIRTH NO. 67 4436 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) REVE, Mrs. FRANCES | | 2. DATE AND HOUR OF DEATH
5-7-67 12:15 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD. B. COUNTY BALTIMORE | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
Church Home & Hospital | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore Md. 1-03 | | | |
| D. STREET ADDRESS (If rural, give location) | | | | | |
| 5. SEX
F | 6. RACE
Wh. | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
married | 8. DATE OF BIRTH
12-5-89? | 9. AGE (In years last birthday)
77? | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY
— | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 12. CITIZEN OF WHAT COUNTRY?
America | | 13. FATHER'S NAME
Joseph Zygo/suski | | | |
| 14. MOTHER'S MAIDEN NAME
Mary Rakowski | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | |
| 16. SOCIAL SECURITY NO.
217-03-1734 | | 17. INFORMANT
Mrs. Frances Barczak | | | |
| 18. ADDRESS
518 S. Montford Ave | | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
Arteriosclerotic Cardiovascular disease | | CAUSE OF DEATH
(A) DUE TO
Arteriosclerotic Cardiovascular disease | | INTERVAL BETWEEN ONSET AND DEATH
year | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Arteriosclerosis, generalized | | (B) DUE TO
Diabetes Mellitus | | year | |
| (C) DUE TO
Cancer | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
— | | 20A. AUTOPSY? (Yes or No) No | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
— | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
— | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
— | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR?
— | |
| 22. I certify that (I) (this hospital) attended the deceased from 2-15-67 19 to 5-7-67 19, that (I) (we) last saw the deceased alive on 5-7-67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Edilia C. MARIANO | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
5-7 | |
| 23C. PHYSICIAN'S NAME (Type)
IDILIA C. MARIANO | | 23D. ADDRESS
CHURCH HOME & HOSPITAL BALTIMORE, MD. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
5/10/67 | | 24C. NAME OF CEMETERY
Sacred Heart Of Mary | |
| 24D. LOCATION (City, town, or county) (State)
7500 German Hill, Baltimore, Md. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 8 1967 | | 25B. NAME OF REGISTRAR
George A. Weber | | 25C. FUNERAL DIRECTOR
George A. Weber | |
| ADDRESS
705 South Ann Street | | | | | |

ZYCOWSKI

No

Address: 1000 1st St
Chicago, Ill.
Phone: 1-234-5678

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | Registered No. 67 4437 | |
|--|-------------------------|---|--|---|--|--|--|--|--|---|--|
| BIRTH NO. 67 4437 | | CERTIFICATE OF DEATH | | | | | | | | | |
| M.E. CASE NO. | | | | | | | | | | 2. DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED
(Type or Print) GIEDRAITIS, VINCENT | | | | | | | | | | MAY 5, 1967 6:10P M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION
ST. AGNES HOSPITAL
CATON AND WILKENS AVENUES
BALTIMORE, MD. 21229 | | | | | | | | | | A. STATE
MARYLAND
B. COUNTY
21223 | |
| | | | | | | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE | |
| | | | | | | | | | | D. STREET ADDRESS (If rural, give location)
1419 HOLLINS STREET | |
| 5. SEX
MALE | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED
WIDOWED | | 8. DATE OF BIRTH
10-24-80 | | 9. AGE (In years last birthday)
78 | | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
NONE | | | | 10B. KIND OF BUSINESS OR INDUSTRY
NONE | | 11. BIRTHPLACE (State or foreign country)
LITHUANIA | | | 12. CITIZEN OF WHAT COUNTRY?
UNKNOWN | | |
| 13. FATHER'S NAME
MICHAEL GIEDRAITIS DEC'D | | | | | | 14. MOTHER'S MAIDEN NAME
AGATHA (MACKSON) GIEDRAITIS DEC'D | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | | | 16. SOCIAL SECURITY NO.
218 14 5100 | | 17. INFORMANT ADDRESS
CATON & WILKENS AVES., BALTO., MD. 21229
HOSPITAL RECORDS-ST. AGNES HOSPITAL | | | | | |
| 18. CAUSE OF DEATH | | | | | | | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
Carcinoma of the lung | | | | | | | | | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | | | | | |
| II | | | | | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | |
| 19A. DATE OF OPERATION
2 | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20A. AUTOPSY? (Yes or No)
YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that XI (this hospital) attended the deceased from APRIL 30 , 19 67 to MAY 5 , 19 67 , that XI (we) last saw the deceased alive on MAY 5 , 19 67 and that in XX (our) opinion death occurred on the date and hour and from the causes stated above XI (We) (did) XXX view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE
<i>Pablo Dibos</i> | | | | | | | | | | 23B. DATE SIGNED
05-06-67 | |
| 23C. PHYSICIAN'S NAME (Type)
PABLO DIBOS, M.D. | | | | | | 23D. ADDRESS
WILKENS & CATON AVES
ST. AGNES HOSPITAL-BALTO., MD 21229 | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | | | 24B. DATE
5-9-67 | | 24C. NAME OF CEMETERY or CREMATORY
Most Holy Redeemer Cem | | | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 8 1967 | | | | 25B. NAME OF REGISTRAR
<i>Robert E. Taylor</i> | | | | 25C. FUNERAL DIRECTOR ADDRESS
Thomas J. Kelly, Inc 1600 Hollins St Balto | | | |

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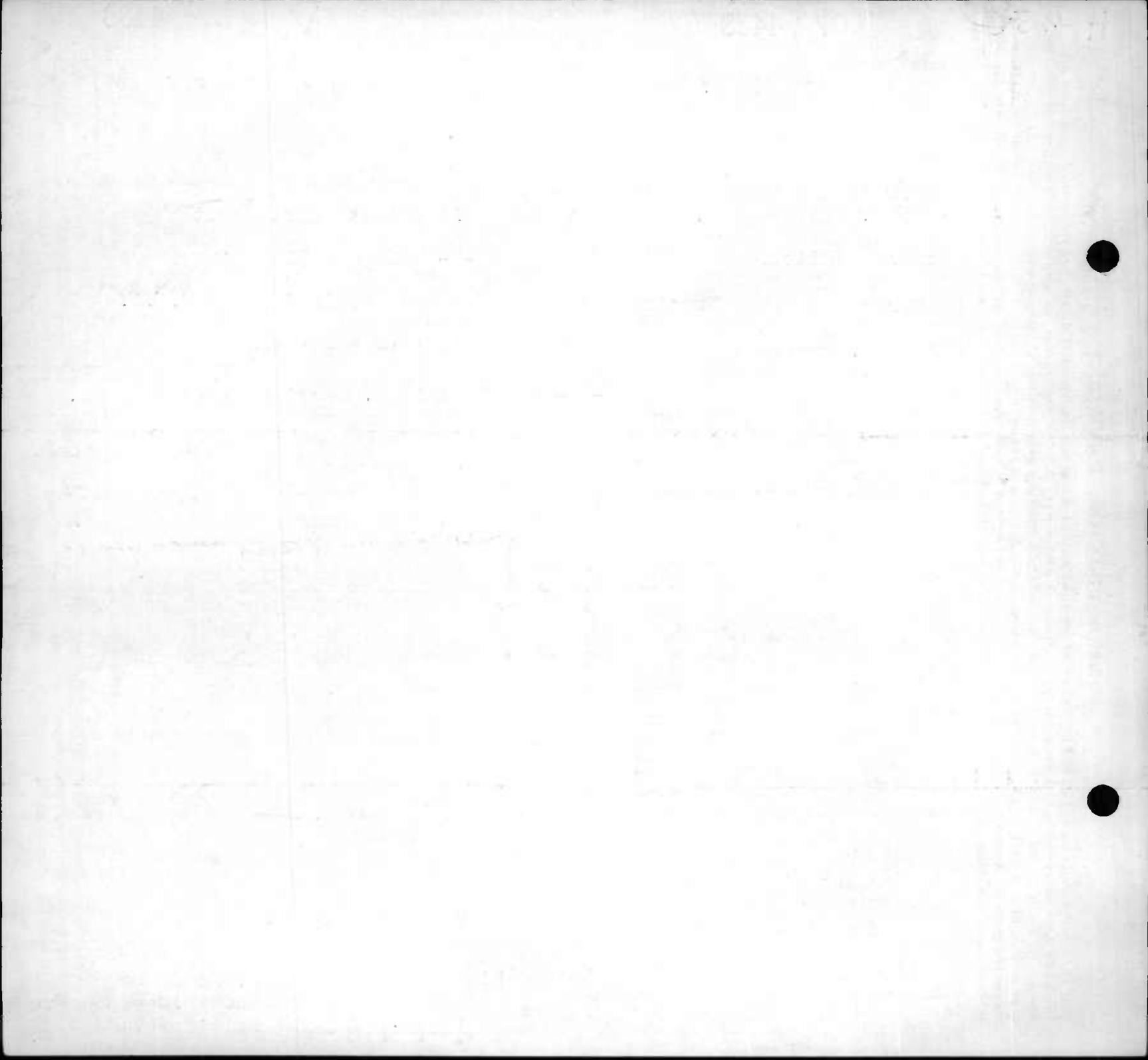
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 67 4438 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 4438 | |
|--|-------------------------|--|--|--|--|
| M.E. CASE NO. | | | CERTIFICATE OF DEATH | | |
| 1. NAME OF DECEASED
(Type or Print) Virginia C. Herring | | | 2. DATE AND HOUR OF DEATH
May 6, 1967 - 4:30 P. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
House in the Pines Nursing Home
2525 W. Belvere Ave. Baltimore, Md | | | A. STATE Md.
B. COUNTY Balt Co. | | |
| | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Pikesville 53-00 | | |
| | | | D. STREET ADDRESS (If rural, give location)
811 Painted Post Court #8 | | |
| 5. SEX
Female | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widowed | 8. DATE OF BIRTH
10-4-1896 | 9. AGE (In years last birthday)
70 | If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Nurse | | 10B. KIND OF BUSINESS OR INDUSTRY
Nursing Home | 11. BIRTHPLACE (State or foreign country)
Western Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. |
| 13. FATHER'S NAME
John C. Draper | | | 14. MOTHER'S MAIDEN NAME
Virginia Enswiller | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
218-32-4798 | 17. INFORMANT
811 Painted Post Rd
Virginia C. Herring Pikesville Md. | | |
| 18. 260X1
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

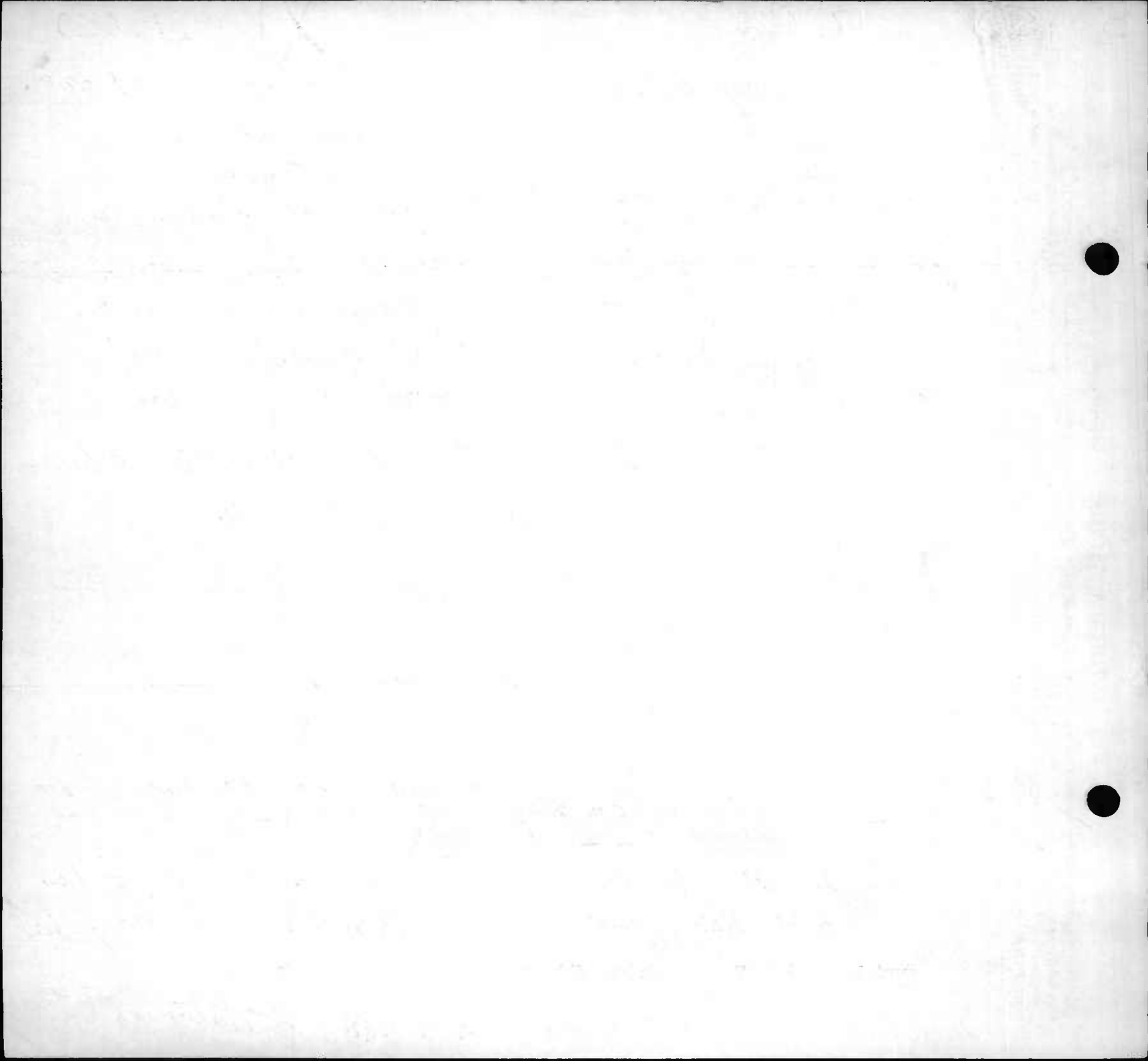
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH
Cardiac failure -
Chronic myocarditis
Cause of cervix | | INTERVAL BETWEEN ONSET AND DEATH
6 months -
10 months -
10 years |
| | | | (A) DUE TO

(B) DUE TO
Diabetes Mellitus
(C) | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 19 46 to May 6 19 67 , that (I) (we) last saw the deceased alive on May 3 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Louis E. Wice | | | | 23B. DATE SIGNED
5/6/67 | |
| 23C. PHYSICIAN'S NAME (Type)
Louis E. WICE | | | | 23D. ADDRESS
920 ST. PAUL ST. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY
Hebrew Friendship | |
| | | | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Md | |
| 25A. DATE REC'D. BY HEALTH DEPT.
MAY 8 1967 | | 25B. NAME OF REGISTRAR
Robert E. Taylor | | 25C. FUNERAL DIRECTOR
Harry N. Armacost | |
| | | | | ADDRESS
4204 Ridgewood Ave
Baltimore, Md 21215 | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

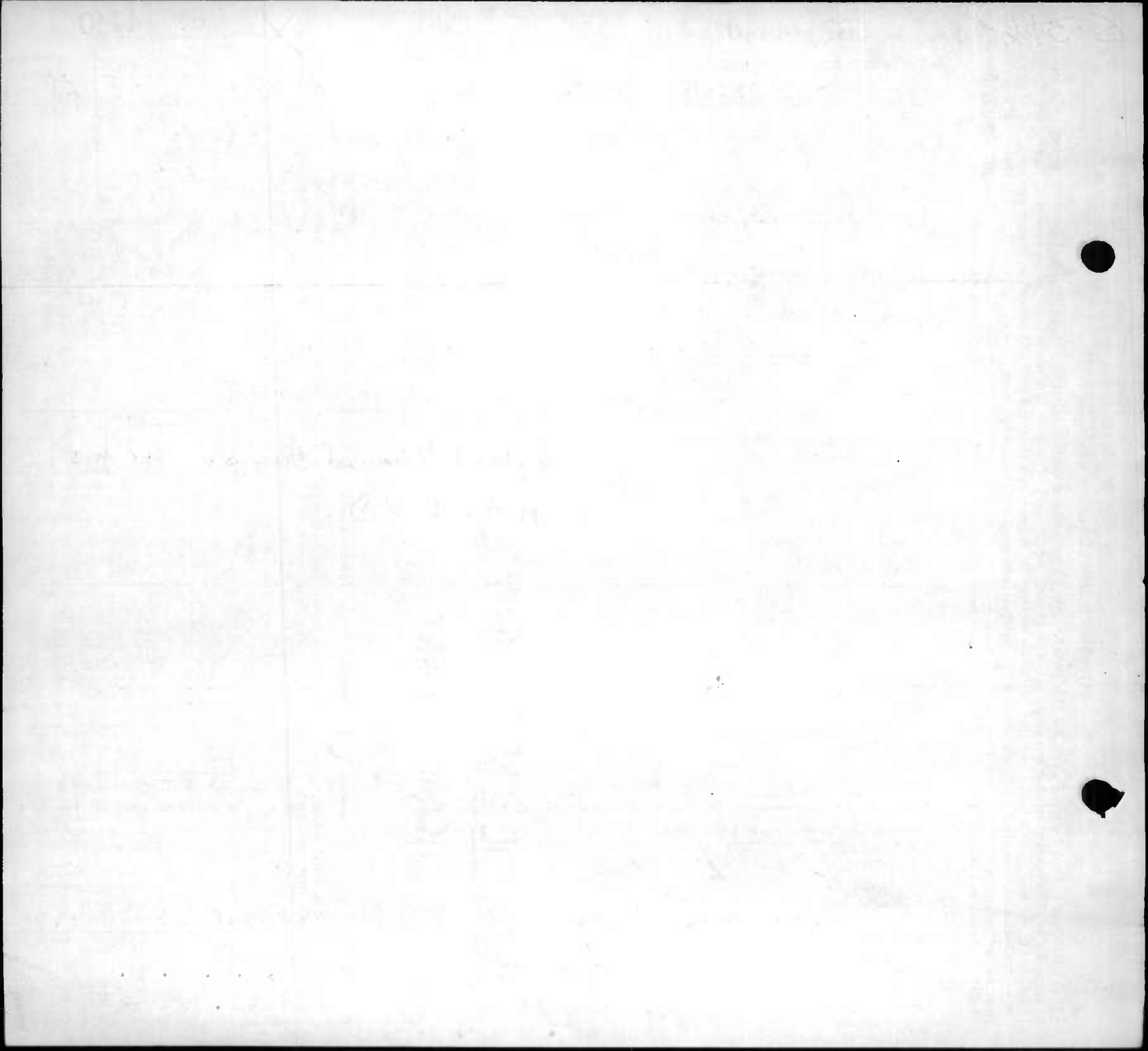
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 4439 | |
|--|-------------------------|---|---|--|--|
| CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. 67 4439 | | | | | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED
(Type or Print) <i>Mr. Mary Schline</i> | | 2. DATE AND HOUR OF DEATH
<i>5/5/67 01:29 P.M.</i> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<i>4 Bon Secours Hospital</i> | | A. STATE <i>Maryland</i> B. COUNTY <i>Balts Co.</i> | | | |
| (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<i>Baltimore 53-00</i> | | | |
| | | D. STREET ADDRESS (If rural, give location)
<i>1017 St. Albans Rd.</i> | | | |
| 5. SEX
<i>Female</i> | 6. RACE
<i>white</i> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<i>married</i> | 8. DATE OF BIRTH
<i>12/25/79</i> | 9. AGE (In years last birthday)
<i>87</i> | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most at working life, even if retired)
<i>no</i> | | 10B. KIND OF BUSINESS OR INDUSTRY
<i>no</i> | | 11. BIRTHPLACE (State or foreign country)
<i>Baltimore</i> | |
| 12. CITIZEN OF WHAT COUNTRY?
<i>U.S.</i> | | | | | |
| 13. FATHER'S NAME
<i>Joseph Denty</i> | | | 14. MOTHER'S MAIDEN NAME
<i>marquerite Denty</i> | | |
| 15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>No</i> | | | 16. SOCIAL SECURITY NO. | | |
| 17. INFORMANT
<i>Family</i> | | | ADDRESS
<i>Same</i> | | |
| 18. <i>43301</i> | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | (A) <i>Acute Cardiac Standstill</i> | | <i>6 hours</i> | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) <i>Complete heart block</i> | | | |
| | | (C) | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
<i>5</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<i>no</i> | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>5th may 1967</i> to <i>5th may 1967</i> , that (I) (we) lost saw the deceased alive on <i>5th may 1967</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<i>J. R. Park</i> M.D. | | | | 23B. DATE SIGNED
<i>5/5/67</i> | |
| 23C. PHYSICIAN'S NAME (Type)
<i>J. R. Park</i> M.D. | | | | 23D. ADDRESS
<i>Bon Secours Hospital</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 24B. DATE
<i>5/8/67</i> | | 24C. NAME of CEMETERY or CREMATORY
<i>Cedar Hill Cem</i> | |
| 24D. LOCATION (City, town, or county) (State)
<i>A A Co Md</i> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<i>MAY 8 1967</i> | | 25B. NAME OF REGISTRAR
<i>R. R. R. R.</i> | | 25C. FUNERAL DIRECTOR
<i>McCully's</i> ADDRESS
<i>237 Patapsco Ave. 25</i> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | | | | | | | | | |
|--|--|---------|--|--|--|------------------|--|---------------------------------|--|---|--|-----------------------------|--|--|--|--|--|--|--|
| BIRTH NO. 67 4440 | | | | | CERTIFICATE OF DEATH | | | | | Registered No. 67 4440 | | | | | | | | | |
| M.E. CASE NO. | | | | | 1. NAME OF DECEASED (Type or Print) | | | | | 2. DATE AND HOUR OF DEATH | | | | | | | | | |
| | | | | | Sudbrook Walter Leroy | | | | | 5-6-67 8:25 M. | | | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | | | | | | |
| | | | | | | | | | | A. STATE B. COUNTY | | | | | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | | | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | | | | | | | |
| 36 Franklin Square Hosp. | | | | | | | | | | Baltimore 9.9. Co | | | | | | | | | |
| | | | | | | | | | | D. STREET ADDRESS (If rural, give location) | | | | | | | | | |
| | | | | | | | | | | 304 3rd Ave. 52-00 | | | | | | | | | |
| 5. SEX | | 6. RACE | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH | | 9. AGE (In years last birthday) | | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | | | | | | |
| Male | | White | | Married | | 11-11-63 | | 63 | | | | | | | | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | | | 11. BIRTHPLACE (State or foreign country) | | | | | | | | | |
| Retired | | | | | Electric Co | | | | | Maryland | | | | | | | | | |
| 13. FATHER'S NAME | | | | | 14. MOTHER'S MAIDEN NAME | | | | | 12. CITIZEN OF WHAT COUNTRY? | | | | | | | | | |
| Charles Sudbrook | | | | | Rose Adams | | | | | U.S.A. | | | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | | 16. SOCIAL SECURITY NO. | | | | | 17. INFORMANT ADDRESS | | | | | | | | | |
| No | | | | | 215 094934 | | | | | Hospital chart. | | | | | | | | | |
| 18. 45-1X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | | | | | | | | | CAUSE OF DEATH | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | |
| | | | | | | | | | | (A) Ruptured Abdominal Aneurysm | | | | | 48 hrs. | | | | |
| | | | | | | | | | | (B) H.A.S.C.V.D. | | | | | | | | | |
| | | | | | | | | | | (C) | | | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | | | | | | | | | |
| 19A. DATE OF OPERATION | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20A. AUTOPSY? (Yes or No) | | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 2 | | | | | | | | | | YES | | | | | YES | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | 21F. HOW DID INJURY OCCUR? | | | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 5-5 1967 to 5-6 1967, that (I) (we) last saw the deceased alive on 5-6 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | |
| 23A. SIGNATURE | | | | | | | | | | 23B. DATE SIGNED | | | | | | | | | |
| Ki Bum Lee M.D. | | | | | | | | | | 5-6-67 | | | | | | | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | | | | | | | 23D. ADDRESS | | | | | | | | | |
| Franklin Square Hospital | | | | | | | | | | Brooklyn, A. A. Co. Md. | | | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | | | | 24B. DATE | | | | | 24C. NAME OF CEMETERY or CREMATORY | | | | | 24D. LOCATION (City, town, or county) (State) | | | | |
| Burial | | | | | 5 10 67 | | | | | Cedar Hill | | | | | Brooklyn, A. A. Co. Md. | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | | | | 25B. NAME OF REGISTRAR | | | | | 25C. FUNERAL DIRECTOR ADDRESS | | | | | | | | | |
| MAY 8 1967 | | | | | Robert E. Taylor | | | | | Mc Gully 130 E. Fort Ave | | | | | | | | | |



BIRTH NO. 67 4441 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 4441

M.E. CASE NO.

| | | | | | | | |
|--|-------------------------|---|---|---|---|--|----------------------------------|
| 1. NAME OF DECEASED
(Type or Print)
WILLIAM Bennett WISE | | | | 2. DATE AND HOUR PRONOUNCED DEAD
May 5, 1967 5:15 P M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

42 Sinai Hospital | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Baltimore | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
42 Sinai Hospital | | | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore | | | |
| | | | | D. STREET ADDRESS (If rural, give location)
2914 Woodland Avenue | | | |
| 5. SEX
Male | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widower | 8. DATE OF BIRTH
Sept. 16, 1908 | 9. AGE (In years last birthday)
58 | If Under 1 Yr. If Under 24 Hrs.
Months Ooys Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Clerk | | 10B. KIND OF BUSINESS OR INDUSTRY
U. S. Post Office | | 11. BIRTHPLACE (State or foreign country)
Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME
William Bennett Wise | | | | 14. MOTHER'S MAIDEN NAME
Mary Hanna Waters | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)
Yes W 2 | | 16. SOCIAL SECURITY NO.
212-09-4282 | | 17. INFORMANT ADDRESS
Mrs. Anna Hurlock, 2914 Woodland Ave | | | |
| 18. CAUSE OF DEATH
I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
Metastatic Carcinoma
(A) DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
Carcinoma of Head of Pancreas.
(B) DUE TO
(C) DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
Yes | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>
Partial | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE
EXAMINER'S NAME (Type)
Charles S. Petty | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DATE SIGNED
5/6/67 | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 23B. DATE
5/9/1967 | | 23C. NAME OF CEMETERY or CREMATORY
Woodlawn Cemetery | | 23D. LOCATION (City, town, or county) (State)
Baltimore, Md. | |
| 24A. DATE REC'D BY HEALTH DEPT.
MAY 8 1967 | | 24B. NAME OF REGISTRAR
Robert E. Farber | | 24C. FUNERAL DIRECTOR
G. Vernon Lenneman | | ADDRESS
4611 Park Heights Ave. | |

19670004449



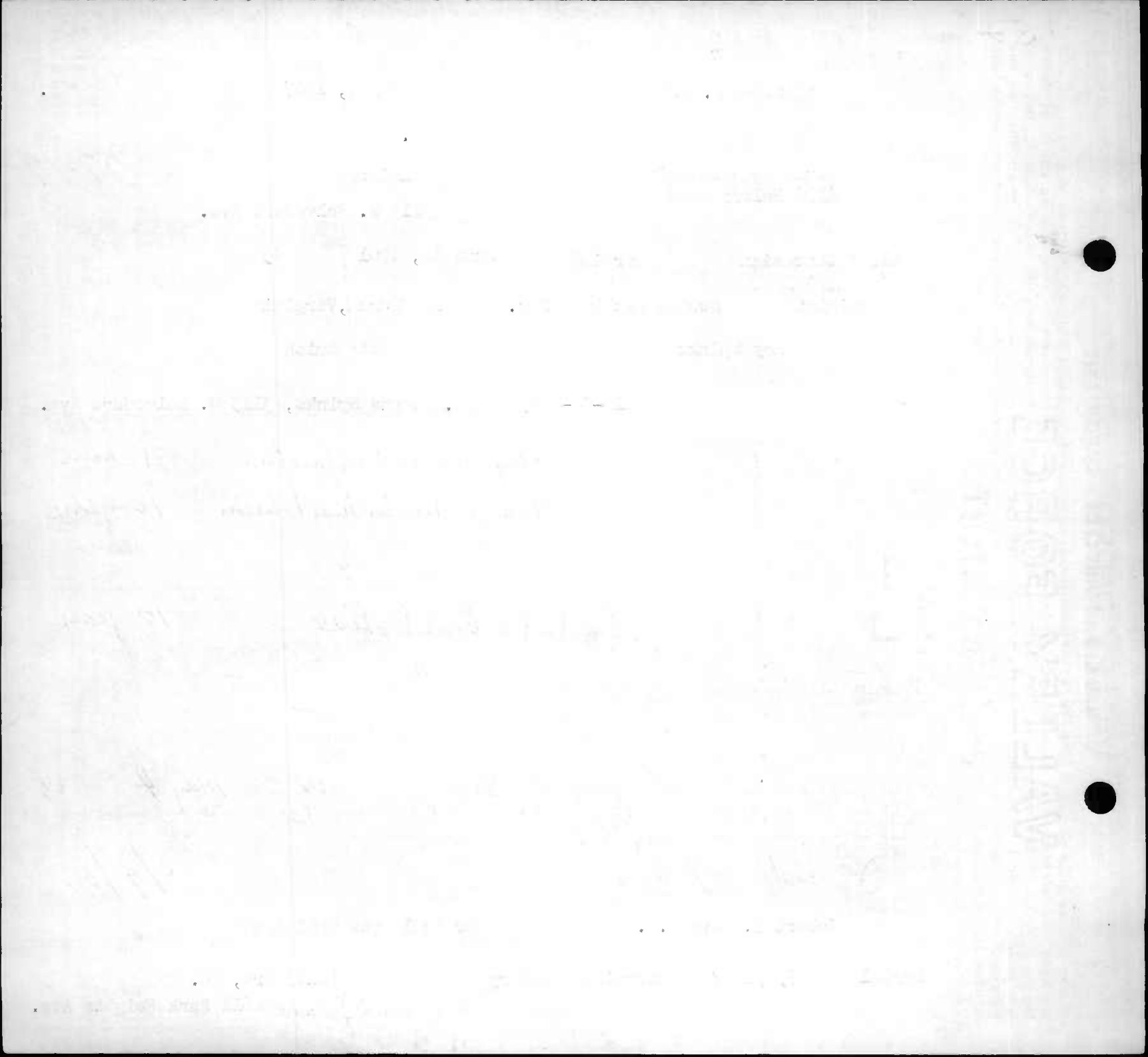
LETY FORGE



Class, 1st

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REGISTERED NO. 67 4442 | |
|--|---|---|--|--|---|
| BIRTH NO. 67 4442 | | CERTIFICATE OF DEATH | | DATE AND HOUR OF DEATH
May 4, 1967 P.M. | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) Howard L. SPINKS | | 2. PLACE OF DEATH IN BALTIMORE, MARYLAND | |
| FULL NAME OF HOSPITAL OR INSTITUTION
90 Gould Convalesarium
6116 Belair Road | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
3115 W. Belvedere Ave. | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | |
| 5. SEX
Male | 6. RACE
Caucasian | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married | 8. DATE OF BIRTH
June 10, 1901 | 9. AGE (In years last birthday)
65 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Machinist | | 10B. KIND OF BUSINESS OR INDUSTRY
Sewing Machine Mfr. | | 11. BIRTHPLACE (State or foreign country)
Falls Church, Virginia | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME
Roy Spinks | | 14. MOTHER'S MAIDEN NAME
Etta Smith | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
212-03-2045A | | 17. INFORMANT ADDRESS
Mrs. Leanna Spinks, 3115 W. Belvedere Ave. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Myocardial infarction | | CAUSE OF DEATH
(A) DUE TO
Arteriosclerotic heart disease
(B) DUE TO
(C) | | INTERVAL BETWEEN ONSET AND DEATH
1 hour
10 years | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Cerebral arteriosclerosis | | 10 years | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
— | | 20A. AUTOPSY? (Yes or No)
No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
— | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
— | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
— | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
— | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR?
— | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan 1967 to May 4 1967, that (I) (we) last saw the deceased alive on April 25 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Robert I. Levy | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
5/4/67 | |
| 23C. PHYSICIAN'S NAME (Type)
Robert I. Levy M.D. | | 23D. ADDRESS
Medical Arts Building | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
5/8/1967 | | 24C. NAME OF CEMETERY OR CREMATORY
Lorraine Cemetery | |
| 24D. LOCATION (City, town, or county) (State)
Baltimore, Md. | | 25A. DATE REC'D BY HEALTH DEPT.
MAY 8 1967 | | | |
| 25B. NAME OF REGISTRAR
Robert E. Farley, M.D. | | 25C. FUNERAL DIRECTOR ADDRESS
G. Kerner Lemmon, 4611 Park Heights Ave. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 4443 | |
|--|--|--|--|--|--|
| BIRTH NO. 67 4443 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) Becker, Mary | | 2. DATE AND HOUR OF DEATH
5/4/67 6:05 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location)
House in the Pines - Bel Air
5837 Belair Road, 01006. | | A. STATE Md.
B. COUNTY | | | |
| 5. SEX F | | 6. RACE W | | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) W | |
| 8. DATE OF BIRTH
5/4/67? | | 9. AGE (In years last birthday) 85 | | 10. CITIZEN OF WHAT COUNTRY? | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
House. | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Md. | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME
Geo. Fritz | | 14. MOTHER'S MAIDEN NAME
McIntire Jorgis | |
| 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Fanny Jane | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
156.21 | | CAUSE OF DEATH
(A) Hepatic Coma
(B) Metastatic Carcinoma of Liver
(C) | | INTERVAL BETWEEN ONSET AND DEATH
2 days, 1 month (known) | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| 20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 21A. DATE OF OPERATION | | 21B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (the hospital) attended the deceased from 5/2/19 67 to 5/4/19 67 , that (I) (we) last saw the deceased alive on 5/2/19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | 23A. SIGNATURE
Albert B Bradley | | 23B. DATE SIGNED
5/5/67 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | 24. LOCATION (City, town, or county) (State) | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| 25D. ADDRESS | | 25E. ADDRESS | | 25F. ADDRESS | |

2/1/10 2/1/10

2/1/10 2/1/10

2/1/10 2/1/10

2/1/10 2/1/10

2/1/10

2/1/10

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital or institution. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 67 4444

| | | | |
|---|---------------------|--|--|
| BIRTH NO. 67 4444 | | M.E. CASE NO. | |
| 1. NAME OF DECEASED
(Type or Print) <i>CAMP, ELMOR</i> | | 2. DATE AND HOUR OF DEATH
<i>MAY 1, 1967 2:20 PM</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<i>Johns Hopkins Hospital</i> | | A. STATE <i>DELAWARE, DOVER.</i>
B. COUNTY <i>221 Highview</i>
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<i>Dover</i>
D. STREET ADDRESS (If rural, give location)
<i>221 Highview</i> | |
| 5. SEX
<i>F</i> | 6. RACE
<i>W</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
<i>M</i> | 8. DATE OF BIRTH
<i>12-23-27</i> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Housewife</i> | | 10B. KIND OF BUSINESS OR INDUSTRY
<i>Home</i> | 9. AGE (In years last birthday)
<i>39</i> |
| 13. FATHER'S NAME
<i>GEORGE WINTERS</i> | | 14. MOTHER'S MAIDEN NAME
<i>ANN HOLINSKEY</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>No</i> | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
<i>Cl. Rec. John's Hopkins Hosp. Balto. Md.</i> | | ADDRESS
<i>Trader Funeral Home, Dover, Del.</i> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
<i>ANOXIA</i> | | INTERVAL BETWEEN ONSET AND DEATH
<i>15 min</i> | |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
<i>Antecedent Causes</i> | | 20. CAUSE OF DEATH
(A) DUE TO
<i>CARDIAC ARREST</i>
(B) DUE TO
<i>RENAL NEOPLASM</i>
(C) DUE TO | |
| 21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
<i>Left Kidney Neoplasm</i> | | 22. DATE OF OPERATION
<i>5/1/67</i> | |
| 23. DATE OF OPERATION
<i>5/1/67</i> | | 24. CONDITION FOR WHICH OPERATION WAS PERFORMED
<i>Left Kidney Neoplasm</i> | |
| 25. DATE OF OPERATION
<i>5/1/67</i> | | 26. AUTOPSY? (Yes or No)
<i>Yes</i> | |
| 27. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
<i>Yes</i> | | 28. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
<i>Yes</i> | |
| 29. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 30. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 31. TIME OF INJURY (Month) (Day) (Year) (Hour)
(APPROX.) | | 32. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 33. HOW DID INJURY OCCUR? | | 34. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | |
| 35. I certify that (I) (this hospital) attended the deceased from <i>4-23-67</i> to <i>5-1-67</i> that (I) (we) last saw the deceased alive on <i>5-1-67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | 36. DATE SIGNED
<i>5/1/67</i> | |
| 37. SIGNATURE
<i>James L. Allen</i> | | 38. DATE SIGNED
<i>5/1/67</i> | |
| 39. PHYSICIAN'S NAME (Type)
<i>JAMES L. ALLEN</i> | | 40. ADDRESS
<i>The Johns Hopkins Hospital</i> | |
| 41. BURIAL CREMATION, REMOVAL (Specify)
<i>Removal</i> | | 42. DATE
<i>5-3-67</i> | |
| 43. NAME OF CEMETERY OR CREMATORY
<i>Arlington National Cemetery</i> | | 44. LOCATION
<i>Arlington, Virginia.</i> | |
| 45. DATE REC'D BY HEALTH DEPT.
<i>MAY 8 1967</i> | | 46. NAME OF REGISTRAR
<i>Robert E. Johnson</i> | |
| 47. FUNERAL DIRECTOR
<i>Johnson Funeral Home</i> | | 48. ADDRESS
<i>8521 Loch Raven</i> | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>67 4445</u> | |
|---|---------------------|---|---|---|--|
| <div style="display: flex; justify-content: space-between;"> BIRTH NO. <u>67 4445</u> CERTIFICATE OF DEATH </div> | | | | | |
| <div style="display: flex; justify-content: space-between;"> M.E. CASE NO. <u>1</u> 1. NAME OF DECEASED (Type or Print) <u>Raymond Eugene Buterbaugh</u> 2. DATE AND HOUR OF DEATH
<u>May 4, 1967</u> <u>10:30 P</u> M. </div> | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<u>US Public Health Service Hospital</u>
<u>3100 Wyman Park Drive</u> | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <u>NJ</u>
B. COUNTY _____
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>Millville</u>
D. STREET ADDRESS (If rural, give location)
<u>303 Columbine Ave.</u> | | |
| 5. SEX
<u>M</u> | 6. RACE
<u>W</u> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<u>Single</u> | 8. DATE OF BIRTH
<u>5/17/37</u> | 9. AGE (In years last birthday)
<u>29</u> | If Under 1 Yr. Months: _____ Days: _____
If Under 24 Hrs. Hours: _____ Min. _____ |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Sand loader</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country)
<u>Pa.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> |
| 13. FATHER'S NAME
<u>Adolph Buterbaugh</u> | | | 14. MOTHER'S MAIDEN NAME
<u>Goldie Knauer</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>175-30-4520</u> | 17. INFORMANT ADDRESS
<u>Records- US PHS Hospital, Balto, Md.</u> | | |
| <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> 1B. <u>204.31</u>
 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
 (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
 <u>Acute passive congestion</u>
 ANTECEDENT CAUSES
 DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
 <u>Acute myelogenous leukemia</u> </div> <div style="width: 10%;"> (A) _____
DUE TO

 (B) _____
DUE TO

 (C) _____ </div> <div style="width: 45%;"> INTERVAL BETWEEN ONSET AND DEATH
 <u>Terminal</u>

 <u>Months</u> </div> </div> | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
<u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<u>yes</u> | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
<u>yes</u> | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Mar. 19</u> 19 <u>67</u> to <u>May 4</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>May 4</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>Michael E. Pelczar MD</u> | | | | 23B. DATE SIGNED
<u>5/5/67</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>Michael E. Pelczar, SA Surgeon (R)</u> M.D. | | | | 23D. ADDRESS
<u>US PHS Hospital, Balto, Md.</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | 24B. DATE
<u>5/8/67</u> | | 24C. NAME OF CEMETERY OR CREMATORY
<u>RICHLAND CEMETERY</u> | |
| 24D. LOCATION (City, town, or county) (State)
<u>CAMBRIA CO., PA.</u> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>MAY 8 1967</u> | | 25B. NAME OF REGISTRAR
<u>Robert E. Taylor</u> | | 25C. FUNERAL DIRECTOR ADDRESS
<u>HOWARD H. HUBBARD 4107 WILKENS AVE. 21229</u> | |

Michael S. Bishop

Michael S. Bishop, 2400 1st St., N.E., Washington, D.C. 20002

Michael S. Bishop, 2400 1st St., N.E., Washington, D.C. 20002

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 4446 | |
|---|--------------|--|--|--|---|
| CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. 67 4446 | | | | | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED
(Type or Print) William W. Harley | | | 2. DATE AND HOUR OF DEATH
5. 6. 67 11.10 P. M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location)
49 North Charles Harp. | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore 24-03 | | |
| D. STREET ADDRESS (If rural, give location)
12 63 William St. | | | | | |
| 5. SEX
M | 6. RACE
W | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married | 8. DATE OF BIRTH
Sept. 14, 1902 | 9. AGE (In years last birthday)
64 yrs | 10. If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Maintenance | | 10B. KIND OF BUSINESS OR INDUSTRY
Soap Co. | | 11. BIRTHPLACE (State or foreign country)
N. C. | |
| 12. CITIZEN OF WHAT COUNTRY?
U S A | | | | | |
| 13. FATHER'S NAME
William Harley | | | 14. MOTHER'S MAIDEN NAME
Martha Kline | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Mrs. Ruth N. Harley |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
4-20-1 I
CAUSE OF DEATH
(A) DUE TO Coronary thrombosis
(B) DUE TO A.V.S.D.
(C) DUE TO
INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
X | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (this hospital) attended the deceased from 5. 5. 19 67 to 5. 6. 19 67, that (I) last saw the deceased alive on 11 P.M. 5. 6. 19 67 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
F. Chabaz | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
5. 6. 67 |
| 23C. PHYSICIAN'S NAME (Type)
W. Kohn | | | 23D. ADDRESS
M.D. | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
5 10 67 | | 24C. NAME OF CEMETERY OR CREMATORY
Moreland Memorial | |
| 24D. LOCATION (City, town, or county) (State)
Balto. Md. | | | | | |
| 25A. DATE REC'D. BY HEALTH DEPT.
MAY 8 1967 | | 25B. NAME OF REGISTRAR
Robert E. Harley | | 25C. FUNERAL DIRECTOR
Mc Gully | |
| | | | | ADDRESS
130 E. Fort Ave | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 4447 | |
|--|---|--|---|---|---|
| BIRTH NO. 67 4447 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) Herman E. Barrow | | 2. DATE AND HOUR OF DEATH
May 6, 1967 940 P. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
4905 PARKTON COURT | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE Md. B. COUNTY Balto.
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore 25-31
D. STREET ADDRESS (If rural, give location)
4905 Parkton Court | | |
| 5. SEX
Male | 6. RACE
Cauc. | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married | 8. DATE OF BIRTH
March 11, 1904 | 9. AGE (In years last birthday)
63 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Clerk | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
West Virginia | |
| 13. FATHER'S NAME
(late) Edward Barrow | | | 14. MOTHER'S MAIDEN NAME
(late) Daisy | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
Mrs. Anne Barrow 4905 Parkton Court | |
| 18. 420.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH
(A) Coronary Thrombosis
DUE TO
(B) Hypertensive Cardiac Vascular Disease
DUE TO
(C) | | INTERVAL BETWEEN ONSET AND DEATH
5/6/67
2yr |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1/10/65 19 5/6 19 67 , that (I) (we) last saw the deceased alive on 5/6 19 67 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Joseph G. Laukaitis MD | | | | 23B. DATE SIGNED
5/8/67 | |
| 23C. PHYSICIAN'S NAME (Type)
Dr. Jos. Laukaitis | | | | 23D. ADDRESS
679 Washington Blvd. Balto Md | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
May 9, 1967 | | 24C. NAME of CEMETERY or CREMATORY
Loudon Park | |
| 24D. LOCATION (City, town, or county) (State)
Balto. Md. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 8 1967 | | 25B. NAME OF REGISTRAR
Philip E. Talbot | | 25C. FUNERAL DIRECTOR ADDRESS
Witzke Funeral Dir. 4101 Edmondson Ave. | |

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BIRTH NO.

67 4448

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

67 4448

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

WILLIAM APPLEBY

2. DATE AND HOUR PRONOUNCED DEAD

5-2-67

11:40 PM.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

3219 LEEDS STREET - Amb. Crew #12

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3219 Leeds Street 21229

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Divorced

8. DATE OF BIRTH

Jan. 17, 1918

9. AGE (In years
last birthday)

49

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Balto., Md.

12. CITIZEN OF
WHAT COUNTRY?
USA

13. FATHER'S NAME

William C. Appleby, Jr.

14. MOTHER'S MAIDEN NAME

Elizabeth

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

yes

WW II

16. SOCIAL
SECURITY NO.

217-09-7252

17. INFORMANT

Mrs. William Trail

ADDRESS

432 Maryland Ave. - 21228

18. 420.0

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic heart disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) _____
DUE TO

(C) _____

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☒

DATE SIGNED

ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

RUSSELL S. FISHER, M.D.

M.D. ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

5-3-67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

5-8-67

23C. NAME OF CEMETERY or CREMATORY

Baltimore National Cem.

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.

MAY 8 1967

24B. NAME OF REGISTRAR

Robert E. Fisher

24C. FUNERAL DIRECTOR

Witzke F. D. - 4101 Edmondson Ave.

ADDRESS

| | | | | | | | |
|-----|-------|-------------|---|-----------|-------------|---------------|----------|
| Yes | WM II | 217-01-7222 | Mr. William F. Hill
132 Maryland Ave. - S.W. | Elizabeth | Balto., Md. | Jan. 17, 1918 | Divorced |
|-----|-------|-------------|---|-----------|-------------|---------------|----------|

| | | | | |
|---------|--------|-----------------------|----------------|---------------------------------|
| Partial | 2-5-57 | Belmont National Can. | Baltimore, Md. | Walter F. D. - ALD Richmond Va. |
|---------|--------|-----------------------|----------------|---------------------------------|

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

F-6316

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. **67 4449**

| | | | |
|---|---------------------------------|---|--|
| BIRTH NO. 67 4449 | | M.E. CASE NO. | |
| 1. NAME OF DECEASED
(Type or Print) Mrs. Frances E. Frederick. | | 2. DATE AND HOUR OF DEATH
May 5/1967 12:55 in AM | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION
34 Bon Secours Hospital | | A. STATE Maryland
B. COUNTY 28-09 | |
| (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE 21229 | |
| | | D. STREET ADDRESS (If rural, give location)
727 Midway Lane | |
| 5. SEX
Fe | 6. RACE
W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
MARRIED | 8. DATE OF BIRTH
3-17-04 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | 9. AGE (In years last birthday)
63 |
| | | 11. BIRTHPLACE (State or foreign country)
Maryland | 12. CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME
Joseph Furst | | 14. MOTHER'S MAIDEN NAME
Carolyn Smith | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS
Rev. Carter |
| 18. 420.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
Acute pulm. edema | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) Recurrent acute myocardial infarct, posterior | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No)
YES |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
YES |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from April 18 1967 to May 5/1967 that (I) (we) last saw the deceased alive on May 5/1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE
A. H. Ghiladi M.D. | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | 23B. DATE SIGNED
May 5/67 |
| 23C. PHYSICIAN'S NAME (Type)
Abdolhomid Ghiladi M.D. | | 23D. ADDRESS
Bon Secours Hospital | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | 24B. DATE
May 8, 1967 | 24C. NAME of CEMETERY or CREMATORY
New Cathedral | 24D. LOCATION (City, town, or county) (State)
Baltimore Maryland |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 8 1967 | | 25B. NAME OF REGISTRAR
Robert E. Taylor | 25C. FUNERAL DIRECTOR ADDRESS
Witzke Funeral Home 4101 Edmondson Ave. |

67 4449

1952

107 Miles (200)

3-17-43

Alameda

Grady

in case

Don Secrest

W. W. Winkler

Forest

Yes

1952

107 Miles

3-17-43

Alameda

Grady

in case

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|---------------------|---|---|--|---|
| BIRTH NO. 67 4450 | | BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | Registered No. 67 4450 | |
| M.E. CASE NO.
1. NAME OF DECEASED
(Type or Print) TARVES, MARGARET A. | | | 2. DATE AND HOUR OF DEATH
5/5/67 19:30 P.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
SINAI HOSPITAL OF BALTIMORE | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY A.A.C.
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
905 Bardswell Rd. - Westview, Catonsville
D. STREET ADDRESS (If rural, give location)
905 Bardswell Rd. 53-00 | | |
| 5. SEX
F | 6. RACE
W | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married | 8. DATE OF BIRTH
5/29/14 | 9. AGE (In years last birthday)
52 | If Under 1 Yr. Months: Ooys: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country)
Illinois | | 12. CITIZEN OF WHAT COUNTRY?
USA |
| 13. FATHER'S NAME
--- Jensen | | | 14. MOTHER'S MAIDEN NAME
--- | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
329-07-1212 | 17. INFORMANT
Maj. Harry J. Tarves
905 Bardswell Rd. - 21228 | | ADDRESS |
| 18. 330X1
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
Subarachnoid + Intracerebral hemorrhage
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Hypertension | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
2e | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Ooy) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (s) (this hospital) attended the deceased from 5/5 1967 to 5/5 1967 , that (I) (we) lost saw the deceased alive on 5/5 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Abe Levy | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
5/5/67 |
| 23C. PHYSICIAN'S NAME (Type)
Abe Levy | | | 23D. ADDRESS
Sinai Hosp | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
5/9/67 | | 24C. NAME OF CEMETERY or CREMATORY
Baltimore National Cem. | |
| 24D. LOCATION (City, town, or county)
Baltimore, Md. | | 24E. LOCATION (State)
Baltimore, Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 8 1967 | | 25B. NAME OF REGISTRAR
Robert E. Taylor | | 25C. FUNERAL DIRECTOR
Witzke F. D. - 4101 Edmondson Ave. | |

B-634

67 4451

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

67 4451

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JOSEPH

BOARDLEY

2. DATE AND HOUR PRONOUNCED DEAD

May 5, 1967

3:00 P

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

1631 Mulberry Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1631 Mulberry Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

M.

8. DATE OF BIRTH

9/15/88

9. AGE (In years
last birthday)

78

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John Boardley

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

215-09-7895

17. INFORMANT

ADDRESS

Irene Boardley 1631 W. Mulberry St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

Arteriosclerotic Cardiovascular Disease.

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m. WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Petty

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

5/6/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

5/9/67

23C. NAME OF CEMETERY or CREMATORY

Mt. Calvary

23D. LOCATION

(City, town, or county)

(State)

Brooklyn, Maryland

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

MAY 8 1967

Charles A. Rice

Charles A. Rice 661 W. Barre St.

1 9 6 7 0 0 0 4 4 5 2

Chas. J. [unclear]

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|---------------------|---|---|---|--|
| BIRTH NO. 67 4452 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 4452 | |
| M.E. CASE NO. | | | 2. DATE AND HOUR OF DEATH | | |
| 1. NAME OF DECEASED
(Type or Print) <u>Ebron, James K.</u> | | | <u>May 7 1967 10:00 A.M.</u> | | |
| 3. PLACE OF DEATH <u>IN</u> BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <u>Md.</u>
B. COUNTY | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>43 South Baltimore General Hospital</u> | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>Baltimore</u> | | |
| | | | D. STREET ADDRESS (If rural, give location)
<u>517 S. Sharp St.</u> | | |
| 5. SEX
<u>M</u> | 6. RACE
<u>C</u> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH
<u>1/26/1900</u> | 9. AGE (In years last birthday)
<u>67</u> | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Chauffeur</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>Retired.</u> | | 11. BIRTHPLACE (State or foreign country)
<u>North Carolina</u> | |
| 13. FATHER'S NAME
<u>Unknown</u> | | | 14. MOTHER'S MAIDEN NAME
<u>Unknown</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
<u>218-10-7077A</u> | | 17. INFORMANT
<u>Alice Ebron 212 W Cross St</u> | |
| 18. <u>422.1 I</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH
(A) <u>Arteriosclerosis cardiovascular disease</u>
DUE TO
(B) _____
DUE TO
(C) _____ | | INTERVAL BETWEEN ONSET AND DEATH
<u>UNKNOWN</u> |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | <u>Cerebral vascular accident, right, mild</u> | | <u>Ty CAR</u> |
| 19A. DATE OF OPERATION
<u>2/</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<u>yes</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that the (this hospital) attended the deceased from <u>May 6 1967</u> to <u>May 7 1967</u> , that the (we) last saw the deceased alive on <u>May 7 1967</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>Gary A. Fleming</u> | | | | 23B. DATE SIGNED
<u>5-7-67</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>GARY A. FLEMING</u> | | | | 23D. ADDRESS
<u>South Baltimore General Hosp.</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>5/19/67</u> | | 24C. NAME OF CEMETERY or CREMATORY
<u>Mt Auburn</u> | |
| 24D. LOCATION
<u>Baltimore Md</u> | | 25A. DATE REC'D BY HEALTH DEPT.
<u>MAY 8 1967</u> | | | |
| 25B. NAME OF REGISTRAR
<u>Isa...</u> | | 25C. FUNERAL DIRECTOR
<u>Charles A. Rice 661 W Bank</u> | | | |

1/25/1900

C. Knapp

for Knapp

for Knapp

212 N 17th St. St. Louis, Mo.

212 N 17th St.
St. Louis, Mo.

Received of C. Knapp
the sum of \$100.00

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 4453 | |
|--|-------------------------|---|-------------------------------------|--|---|
| BIRTH NO. 67 4453 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) SANDS THOMAS A | | 2. DATE AND HOUR OF DEATH
5-3-67 7:20 A M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
40 ST AGNES HOSPITAL | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE MD
B. COUNTY

C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE
D. STREET ADDRESS (If rural, give location)
1301 LINDEN AVENUE | | | |
| 5. SEX
MALE | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED
WIDOWED | 8. DATE OF BIRTH
11-23-84 | 9. AGE (In years last birthday)
83 82 | If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
RETIRED | | 10B. KIND OF BUSINESS OR INDUSTRY
Plumber | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | |
| 13. FATHER'S NAME
WILLIAM | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
217 01 3151 | | 17. INFORMANT ADDRESS
ST AGNES HOSPITAL CATON & WILKENS AVE. | |
| 18. 451X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
RUPTURED ABDOMINAL AORTIC ANEURYSM | | CAUSE OF DEATH
(A) DUE TO
(B) DUE TO
(C) DUE TO
ARTERIOSCLEROSIS | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from MAY 1 19 67 to MAY 3 19 67 , that (I) (we) last saw the deceased alive on MAY 3 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Jaime V. Del Pilar | | | | 23B. DATE SIGNED
5-3-67 | |
| 23C. PHYSICIAN'S NAME (Type)
JAIME V. DEL PILAR | | 23D. ADDRESS
CATON & WILKENS AVE. BALTIMORE MD | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
MAY 6 1967 | | 24C. NAME OF CEMETERY or CREMATORY
Northwood Cemetery | |
| 24D. LOCATION (City, town, or county) (State)
Dorsey Maryland | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 8 1967 | | 25B. NAME OF REGISTRAR
Philip E. Fadden | | 25C. FUNERAL DIRECTOR ADDRESS
Amrose Inc 1328 Sulphur Spring Rd. | |

1:20 A

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 4454 | |
|--|------------------|---|-----------------------------|--|---|
| BIRTH NO. 67 4454 | | M.E. CASE NO. | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED
(Type or Print) BERNARDY FRANCES | | 2. DATE AND HOUR OF DEATH
MAY 4 1967 | | 1:30 P M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD
B. COUNTY | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE | |
| FULL NAME OF HOSPITAL OR INSTITUTION
ST AGNES HOSPITAL
40 | | D. STREET ADDRESS (If rural, give location)
5703 PHILLIPS ST. | | P.P.C. 52-00 | |
| 5. SEX
FEMALE | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
W | 8. DATE OF BIRTH
11-3-80 | 9. AGE (In years lost birthday)
86 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Europe | |
| 13. FATHER'S NAME
WALTER | | 14. MOTHER'S MAIDEN NAME
JOANNA CHOVANCE | | 12. CITIZEN OF WHAT COUNTRY? | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No. | | 16. SOCIAL SECURITY NO.
214 46 9251 | | 17. INFORMANT ADDRESS
ST AGNES HOSPITAL CATON & WILKENS AVE | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)
DISEASE OR CONDITION CAUSING DEATH
Acute pulmonary edema | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from MAY 4 1967, to MAY 4 1967, that (I) (we) last saw the deceased alive on MAY 4 1967, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | 23A. SIGNATURE
S. Korbuly | | 23B. DATE SIGNED
5-4-67 | |
| 23C. PHYSICIAN'S NAME (Type)
S. KORBULY | | 23D. ADDRESS
CATON & WILKENS AVE. BALTO MD | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
B | | 24B. DATE
5/8/67 | | 24C. NAME OF CEMETERY OR CREMATORY
Cedar Hill | |
| 24D. LOCATION (City, town, or county) (State)
Balt. | | 25A. DATE REC'D BY HEALTH DEPT.
MAY 8 1967 | | 25B. NAME OF REGISTRAR
D. E. Tolson | |
| 25C. FUNERAL DIRECTOR
McGee | | 25D. ADDRESS
737 Patapsco Ave | | | |

1:50 PM

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | Registered No. 67 4455 | |
|--|--|-------------------------|--|---|--|--|--|--|--|---|--|
| BIRTH NO. 67 4455 | | | | | | | | | | | |
| M.E. CASE NO. | | | | | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) NILS BORJESSON | | | | | | 2. DATE AND HOUR OF DEATH
5-5-67 12:45 PM | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND
Lincoln Memorial Nursing Home | | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE MARYLAND
B. COUNTY | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
27 N. CAREY ST | | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE | | | | | |
| (If not in hospital or institution, give street address or location) | | | | | | D. STREET ADDRESS (If rural, give location)
27 N. CAREY ST | | | | | |
| 5. SEX
male | | 6. RACE
white | | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
widowed | | 8. DATE OF BIRTH
2-1-1901 | | 9. AGE (In years last birthday)
66 | | 10. CITIZEN OF WHAT COUNTRY? | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | | 11. BIRTHPLACE (State or foreign country)
unknown | | | |
| 13. FATHER'S NAME
unknown | | | | | | 14. MOTHER'S MAIDEN NAME
unknown | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO.
217-164863-A | | 17. INFORMANT ADDRESS | | | | | |
| 18. 420.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
CORONARY THROMBOSIS | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | |
| 19A. DATE OF OPERATION
0 | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 5/5/67 to 5/5/67 that (I) (we) last saw the deceased alive on 5/5/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE
Anna Tennarine M.D. | | | | | | 23B. DATE SIGNED
5/5/67 | | | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | |
| 23C. PHYSICIAN'S NAME (Type)
Anna Tennarine | | | | | | 23D. ADDRESS
5519 KENNISON AVE BALTIMORE MD | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial 5/6/67 | | | | 24B. DATE
5/6/67 | | | | 24C. NAME OF CEMETERY OR CREMATORY
Int. Calvary | | | |
| 24D. LOCATION
Baltimore MD | | | | 24E. CITY, TOWN, OR COUNTY
Baltimore MD | | | | 24F. STATE
MD | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 8 1967 | | | | 25B. NAME OF REGISTRAR
R. B. E. Edwards | | | | 25C. FUNERAL DIRECTOR
William S. C. Common | | | |
| 25D. ADDRESS
2513 Market St. | | | | | | | | | | | |

Miss B. J. Carson

Mr. H. Carey

Miss

Col. J. H. Carson

2/2/2

2/2/2 # 1/1/2

Miss J. H. Carson

Miss J. H. Carson

2/2/2

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|-------------------------|---|--|--|---|
| BIRTH NO. 67 4456 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 4456 | |
| CERTIFICATE OF DEATH | | | | | |
| M.E. CASE NO. | | | 5/4/67 | | |
| 1. NAME OF DECEASED
(Type or Print)
WALTER BODE | | | 2. DATE AND HOUR OF DEATH
10:57 PM 5/4 P.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY A.A. Co. | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
44 Union Memorial Hospital | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
RURAL - CROWNsville 32-00 | | |
| | | | D. STREET ADDRESS (If rural, give location)
766 Dogwood Road Arden on the Severn | | |
| 5. SEX
Male | 6. RACE
White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
Married | 8. DATE OF BIRTH
11/21/00 | 9. AGE (In years last birthday)
66 | If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Semi-Retired | | 10B. KIND OF BUSINESS OR INDUSTRY
Construction | | 11. BIRTHPLACE (State or foreign country)
Germany | |
| 13. FATHER'S NAME
Frederick Bode Construction | | | 12. CITIZEN OF WHAT COUNTRY?
USA | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | 16. SOCIAL SECURITY NO.
216-09-8028 | | 17. INFORMANT ADDRESS
Mrs Catherine Bode 766 Dogwood Road |
| 18. I
162.1 I | | | CAUSE OF DEATH | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Antecedent Causes | | | (A) DUE TO
Out Cell cancer gang c metastases 5-6 m. | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (B) DUE TO | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | (C) | | |
| 19A. DATE OF OPERATION
4/13/67 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
Extent of Lung tumor | | 20A. AUTOPSY? (Yes or No)
NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)
(APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that the (this hospital) attended the deceased from 4/8 19 67 to 5/4 19 67 , that the (we) lost saw the deceased alive on 5/4 19 67 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. We (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
D. S. Schwartz | | | | 23B. DATE SIGNED
5/4/67 | |
| 23C. PHYSICIAN'S NAME (Type)
DAVID S. SCHWARTZ, M.D. | | | | 23D. ADDRESS
THE UNION MEMORIAL HOSPITAL | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
5-8-1967 | | 24C. NAME of CEMETERY or CREMATORY
Gardens of Faith Cemetery | |
| 24D. LOCATION
Baltimore Co. Md. | | 25A. DATE RECD BY HEALTH DEPT.
MAY 8 1967 | | | |
| 25B. NAME OF REGISTRAR
Robert E. Taylor | | 25C. FUNERAL DIRECTOR ADDRESS
Lissagah Funeral Home 7401 Balan Rd (36) | | | |

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WATERS 10 DE

11/21/00

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WATERS 10 DE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 67 4457 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 4457 | |
|--|------------------|---|-----------------------------|---|----------------------------|--|-----------------------------|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) Eberling, Catherine F. | | | | 2. DATE AND HOUR OF DEATH
5-4-67 6:20 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
40 St. Agnes Hosp. | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Baltimore
C. CITY OR TOWN (If outside city limits, write RURAL and give township) 20-08
D. STREET ADDRESS (If rural, give location)
121 South Collins Ave. | | | |
| 5. SEX
F | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widowed | 8. DATE OF BIRTH
4-18-76 | 9. AGE (In years last birthday)
91 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
House Wife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Balto. Md. | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
William Henry Tribbe | | | | 14. MOTHER'S MAIDEN NAME
Mary Buxmeier | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
213-54-0336 | | 17. INFORMANT
Balto. Md.
Miss. Frances Eberling 121 S. Collins Ave. | | ADDRESS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
CAUSE OF DEATH
(A) Cardogenic Shock
(B) Acute Myocardial Infarction
(C) ASCVD
INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| 19. DATE OF OPERATION
6 | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 5-4-67 19 to 5-4-67 19, that (I) (we) last saw the deceased alive on 5-4-67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
F. H. Weiss | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
5-4-67 | |
| 23C. PHYSICIAN'S NAME (Type)
F. H. Weiss | | | | 23D. ADDRESS
M.D. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
May 8, 1967 | | 24C. NAME OF CEMETERY or CREMATORY
New Cathedral Cem. | | 24D. LOCATION (City, town, or county) (State)
XX Balto. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 8 1967 | | 25B. NAME OF REGISTRAR
Robert E. Taylor | | 25C. FUNERAL DIRECTOR
G. Truman Schwab | | ADDRESS
3512 Frederick Ave. Balto. Md. | |

ARTICLE 10

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|---|--|---|--|
| <p style="font-size: 24pt; margin: 0;">67 4458</p> <p style="font-size: 24pt; margin: 0;">67 4458</p> | | <p style="font-size: 24pt; margin: 0;">67 4458</p> | |
| <p>BIRTH NO.</p> | | <p>CERTIFICATE OF DEATH</p> | |
| <p>M.E. CASE NO.</p> | | <p>Registered No.</p> | |
| <p>1. NAME OF DECEASED
(Type or Print) <u>Thomas B. Tressler</u></p> | | <p>2. DATE AND HOUR OF DEATH
<u>5-4-1967</u> <u>1:30 P.</u> M.</p> | |
| <p>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<u>South Baltimore General Hosp.</u></p> | | <p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <u>Maryland</u> B. COUNTY <u>25</u>
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> # <u>21230</u>
D. STREET ADDRESS (If rural, give location) <u>3712 PENNINGTON AVE.</u></p> | |
| <p>5. SEX <u>M.</u></p> | <p>6. RACE <u>White</u></p> | <p>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Div.</u></p> | <p>8. DATE OF BIRTH <u>9-9-1904</u></p> |
| <p>9. AGE (In years last birthday) <u>62</u></p> | | <p>If Under 1 Yr. Months Days</p> | <p>If Under 24 Hrs. Hours Min.</p> |
| <p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>W.T. Campbell Co.</u></p> | | <p>10B. KIND OF BUSINESS OR INDUSTRY <u>Watchman</u></p> | |
| <p>11. BIRTHPLACE (State or foreign country) <u>Pa.</u></p> | | <p>12. CITIZEN OF WHAT COUNTRY? <u>USA</u></p> | |
| <p>13. FATHER'S NAME <u>Carbin Kirby Tressler</u></p> | | <p>14. MOTHER'S MAIDEN NAME <u>Bertha Boyer</u></p> | |
| <p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u></p> | | <p>16. SOCIAL SECURITY NO. <u>178-05-6310</u></p> | <p>17. INFORMANT <u>Fam. / y</u></p> |
| <p>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
<u>Pneumonia "Left Lung"</u>
<u>aspiration</u>
<u>alcoholism</u></p> | | <p>INTERVAL BETWEEN ONSET AND DEATH
<u>6 days</u>
<u>5 years</u></p> | |
| <p>ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> | | <p>CAUSE OF DEATH
(A) <u>Pneumonia "Left Lung"</u>
(B) <u>aspiration</u>
(C) <u>alcoholism</u></p> | |
| <p>II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p> | | <p><u>Cirrhosis of liver, alcoholic</u>
<u>haemangioma of kidney</u>
<u>5 years</u></p> | |
| <p>19A. DATE OF OPERATION <u>2</u></p> | <p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>2</u></p> | <p>20A. AUTOPSY? (Yes or No) <u>Yes</u></p> | <p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u></p> |
| <p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/></p> | <p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p> | <p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p> | |
| <p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)</p> | <p>21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input checked="" type="checkbox"/></p> | <p>21F. HOW DID INJURY OCCUR?</p> | |
| <p>22. I certify that (this hospital) attended the deceased from <u>4-29</u> 19<u>67</u> to <u>120pm 5-4</u> 19<u>67</u>. that (we) last saw the deceased alive on <u>5-4</u> 19<u>67</u> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p> | | | |
| <p>23A. SIGNATURE <u>Rifat Abouy</u></p> | | <p>M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/></p> | <p>23B. DATE SIGNED <u>5-5-67</u></p> |
| <p>23C. PHYSICIAN'S NAME (Type) <u>Rifat Abouy</u></p> | | <p>23D. ADDRESS <u>1213 Light St.</u></p> | |
| <p>24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u></p> | <p>24B. DATE <u>5-8-67</u></p> | <p>24C. NAME OF CEMETERY OR CREMATORY <u>Oddfellows Cemetery</u></p> | <p>24D. LOCATION (City, town, or county) (State) <u>Shenokin, Penna</u></p> |
| <p>25A. DATE REC'D BY HEALTH DEPT. <u>MAY 8 1967</u></p> | | <p>25B. NAME OF REGISTRAR <u>Robert E. Taylor</u></p> | |
| <p>25C. FUNERAL DIRECTOR <u>John N. Hehn</u></p> | | <p>ADDRESS <u>4200 Pennington Ave - Baltimore 26</u></p> | |

1. Name of deceased
2. Date of death
3. Place of death
4. Cause of death
5. Age at death
6. Sex
7. Race
8. Religion
9. Marital status
10. Occupation
11. Education
12. Social status
13. Family history
14. Medical history
15. Mental history
16. Physical examination
17. Laboratory tests
18. Pathological findings
19. Post-mortem examination
20. Burial or cremation

1. Name of deceased
2. Date of death
3. Place of death
4. Cause of death
5. Age at death
6. Sex
7. Race
8. Religion
9. Marital status
10. Occupation
11. Education
12. Social status
13. Family history
14. Medical history
15. Mental history
16. Physical examination
17. Laboratory tests
18. Pathological findings
19. Post-mortem examination
20. Burial or cremation

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | |
|--|--|---------------------|--|---|--|--|--|--|---|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| Registered No. 67 4459 | | | | | | | | | | | |
| BIRTH NO. 67 4459 | | | | | | | | | | | |
| M.E. CASE NO. | | | | | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) <i>Hattie B. Pickering</i> | | | | | | 2. DATE AND HOUR OF DEATH
<i>5/5/67 9:05 A.M.</i> | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <i> Md. </i> B. COUNTY <i> A.A.C. 52-00 </i> | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<i>905 Bel Air Housing Home</i> | | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<i>Ochlocknee Beach</i> | | | | | |
| | | | | | | D. STREET ADDRESS (If rural, give location)
<i>7806 Ashboa Jr.</i> | | | | | |
| 5. SEX
<i>F</i> | | 6. RACE
<i>W</i> | | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<i>W</i> | | 8. DATE OF BIRTH
<i>7-21-92</i> | | 9. AGE (In years last birthday)
<i>74</i> | | 10. If Under 1 Yr. Months Days | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Home</i> | | | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | 11. BIRTHPLACE (State or foreign country)
<i>Md.</i> | | |
| 12. CITIZEN OF WHAT COUNTRY? | | | | | | | | | | | |
| 13. FATHER'S NAME
<i>Oswald E. Schoenfelder</i> | | | | | | 14. MOTHER'S MAIDEN NAME
<i>Kenice A. Fangerman</i> | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>No</i> | | | | | | 16. SOCIAL SECURITY NO. | | | 17. INFORMANT
<i>Family</i> | | |
| 18. <i>420.11</i> | | | | | | CAUSE OF DEATH | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | | | (A) <i>Acute Myocardial Infarction</i> | | | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | (B) <i>Congestive Heart Failure</i> | | | | | |
| | | | | | | (C) <i>Arteriosclerotic Heart Disease</i> | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | |
| 19A. DATE OF OPERATION
<i>0</i> | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>2/9/1967</i> to <i>5/5/1967</i> , that (I) (was) last saw the deceased alive on <i>4/18/1967</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (was) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE
<i>Robert B. Bradley</i> | | | | | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
<i>5/5/67</i> | |
| 23C. PHYSICIAN'S NAME (Type) | | | | | | | | 23D. ADDRESS
M.D. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>13</i> | | | | 24B. DATE
<i>5/8/67</i> | | | | 24C. NAME OF CEMETERY OR CREMATORY
<i>Baltimore</i> | | | |
| | | | | 24D. LOCATION (City, town, or county) (State)
<i>Balto Md</i> | | | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | | | 25B. NAME OF REGISTRAR
<i>John E. Fangerman</i> | | | | 25C. FUNERAL DIRECTOR
<i>Hy Glegg - 2376 Patapsco Ave</i> | | | |
| | | | | ADDRESS | | | | | | | |

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 4460BIRTH NO. 67 4460

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JAMES A. CARTER

2. DATE AND HOUR PRONOUNCED DEAD

May 5, 1967

12:05 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Provident Hospital

(DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

703 Mosher Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

Jan. 31, 1922

9. AGE (In years
last birthday)

45

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Mechanic

10B. KIND OF BUSINESS OR INDUSTRY

Gov't

11. BIRTHPLACE (State or foreign country)

Balto., Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Lymon Carter

14. MOTHER'S MAIDEN NAME

Eloise Jordon

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

Yes

WWII

16. SOCIAL
SECURITY NO.

218-14-8577

17. INFORMANT

ADDRESS

Mrs. Rosena Carter 535 N. Longwood St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

No

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT NOT WHILE
WORK AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

May 5, 1967

23A. BURIAL-CREATION,
REMOVAL (Specify)

Burial

23B. DATE

5/9/67

23C. NAME OF CEMETERY or CREMATORY

Balto National Cem.

23D. LOCATION (City, town, or county)

Balto., Md.

24A. DATE REC'D BY HEALTH DEPT.

MAY 8 1967

24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

Wm C March 928 E. North Ave.

ADDRESS

WALLACE
FORD

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 4461 | |
|---|-------------------------|--|-------------------------------------|--|---|
| BIRTH NO. 67 4461 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) <i>EVELYN SEEGER Boyd</i> | | 2. DATE AND HOUR OF DEATH
<i>5/7/67</i> <i>5²⁵ A.M.</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<i>Union Memorial Hospital</i> | | A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore Co</i> | | | |
| (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<i>Towson</i> <i>53-00</i> | | | |
| | | D. STREET ADDRESS (If rural, give location)
<i>204 E. Joppa Rd #04</i> | | | |
| 5. SEX
<i>Female</i> | 6. RACE
<i>White</i> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<i>Married</i> | 8. DATE OF BIRTH
<i>11-11-03</i> | 9. AGE (In years last birthday)
<i>63</i> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>At Home</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<i>Pennsylvania</i> | |
| 12. CITIZEN OF WHAT COUNTRY?
<i>United States</i> | | 13. FATHER'S NAME
<i>Henry C. Seeger</i> | | 14. MOTHER'S MAIDEN NAME
<i>Emily Zipple</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>No</i> | | 16. SOCIAL SECURITY NO.
<i>None</i> | | 17. INFORMANT ADDRESS
<i>MARK K Boyd, Sr - Same</i> | |
| 18. <i>331X I</i> | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH
<i>? 48 hrs.</i> | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) DUE TO
<i>Cerebral Vascular Accident</i> | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO | | | |
| (C) DUE TO | | | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
<i>○</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<i>No</i> | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that <i>(M)</i> (this hospital) attended the deceased from <i>5/5</i> 19 <i>67</i> to <i>5/7</i> 19 <i>67</i> , that <i>(M)</i> (we) last saw the deceased alive on <i>5/7</i> 19 <i>67</i> and that in <i>(M)</i> (our) opinion death occurred on the date and hour and from the causes stated above. <i>(M)</i> (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<i>John R Vaughn Jr.</i> | | | | 23B. DATE SIGNED
<i>5/7/67</i> | |
| 23C. PHYSICIAN'S NAME (Type)
<i>DR JOHN R VAUGHN JR</i> | | | | 23D. ADDRESS
<i>THE UNION MEMORIAL HOSPITAL</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>BURIAL</i> | | 24B. DATE
<i>5-10-67</i> | | 24C. NAME OF CEMETERY OR CREMATORY
<i>LORRAINE Cemetery</i> | |
| 24D. LOCATION (City, town, or county) (State)
<i>Baltimore, Md</i> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<i>MAY 8 1967</i> | | 25B. NAME OF REGISTRAR
<i>John R Vaughn Jr.</i> | | 25C. FUNERAL DIRECTOR ADDRESS
<i>Ellsworth ARMACOST - 4601 Lib Heights</i> | |

Henry C. Rogers

Female White Mammal
Union Memorial Hospital

Car. J. C. Rogers
Pennsylvania
United States

11-11-02 62
300 E. 10th St
Tomb

United States
2/1/02

40

2/1/02

2/1/02

2/1/02

2/1/02

2/1/02

John C. Rogers

Central Union for Animals 2/1/02

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|--|--------------|---|------------------------------|--|----------------------------|--|-----------------------------|
| BIRTH NO. 67 4462 | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | Registered No. 67 4462 | |
| 1. NAME OF DECEASED
(Type or Print) MR. FRANK L. PORCELLA | | | | 2. DATE AND HOUR OF DEATH
5/6/67 1:05A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Church Home & Hospital
35 | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore Zone 21231 2-02
D. STREET ADDRESS (If rural, give location)
1831 Gough St. | | | |
| 5. SEX
M | 6. RACE
W | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
MARRIED | 8. DATE OF BIRTH
10-20-99 | 9. AGE (In years last birthday)
67 YRS. | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Steel Worker-Cutter | | 10B. KIND OF BUSINESS OR INDUSTRY
OLES ENVELOPE CO. | | 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
AMERICA | |
| 13. FATHER'S NAME
John Porcella | | | | 14. MOTHER'S MAIDEN NAME
Mary Solial | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
215-03-6493 | | 17. INFORMANT ADDRESS
JOSEPHINE PORCELLA 1831 GOUGH STREET | | | |
| 18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
540.11
Pulmonary Edema
INTERVAL BETWEEN ONSET AND DEATH
Few hours
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.
(A) DUE TO
(B) DUE TO
(C) DUE TO
Acute Myocardial Infarction
Atherosclerosis & Pneumonia
Few hours.
Few days.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
SURGERY (Closure Perforated Peptic ulcer)
Few hours. | | | | | | | |
| 19A. DATE OF OPERATION
5/5/67 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
PERFORATED PEPTIC ULCER | | 20A. AUTOPSY? (Yes or No)
NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 5/3/67 1967 to May 6, 1967, that (I) (we) last saw the deceased alive on 5/6/67 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
Krishna Reddy | | | | 23B. DATE SIGNED | | | |
| 23C. PHYSICIAN'S NAME (Type)
KRISHNA REDDY, M.D. | | | | 23D. ADDRESS
CHURCH HOME & HOSPITAL; BALTIMORE | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
5/10/67 | | 24C. NAME OF CEMETERY OR CREMATORY
HOLY ROSARY CEMETERY | | 24D. LOCATION (City, town, or county) (State)
GERMAN HILL RD MD. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR
MAY 8 1967 | | 25C. FUNERAL DIRECTOR ADDRESS
DIPPEL BRAS INC 1800 E LOMBARD ST | | | |

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John Parcella

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May 20/10

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10-20 10 10/10

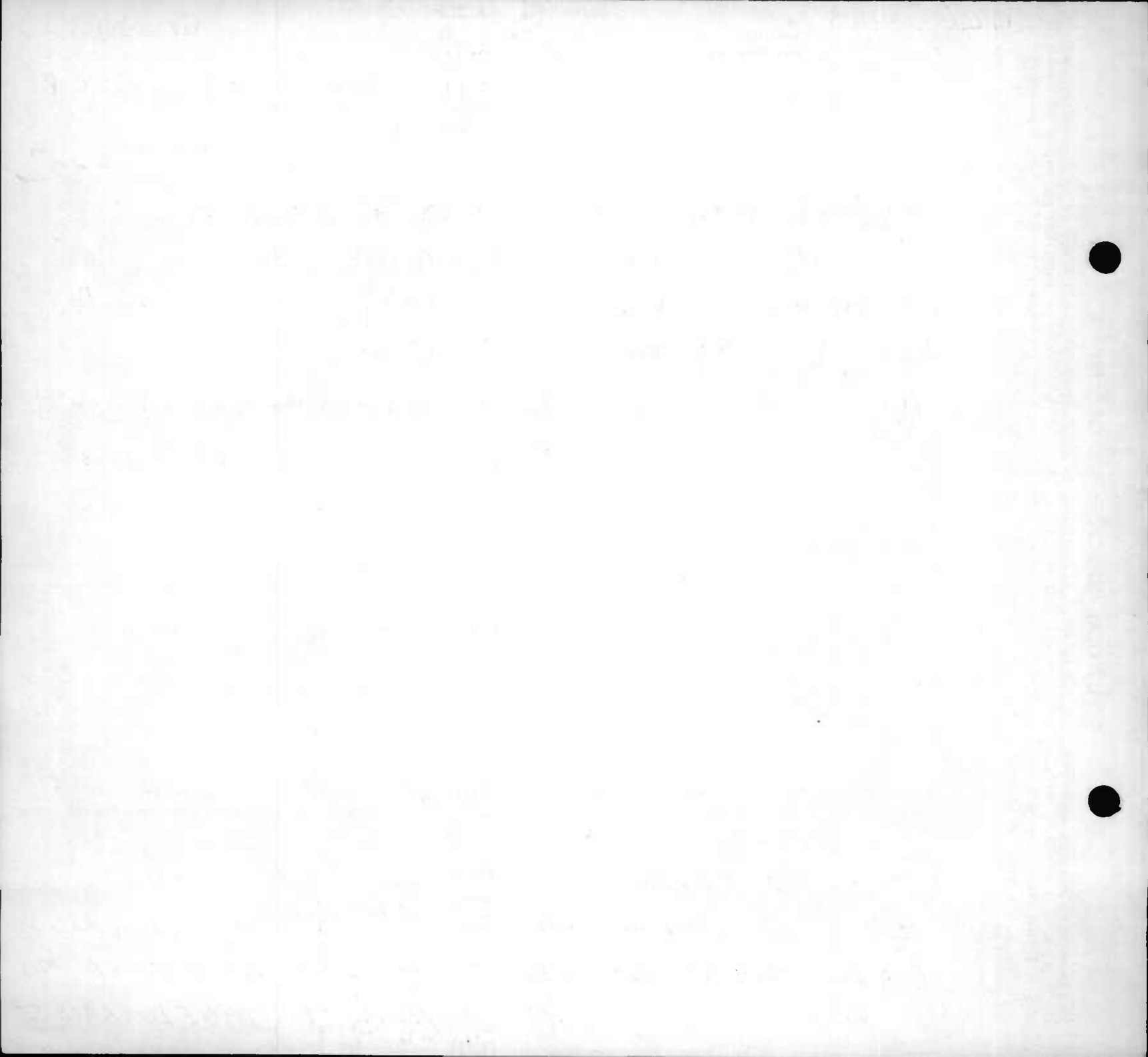
1931 Graph 10

P. House 20-20/10

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

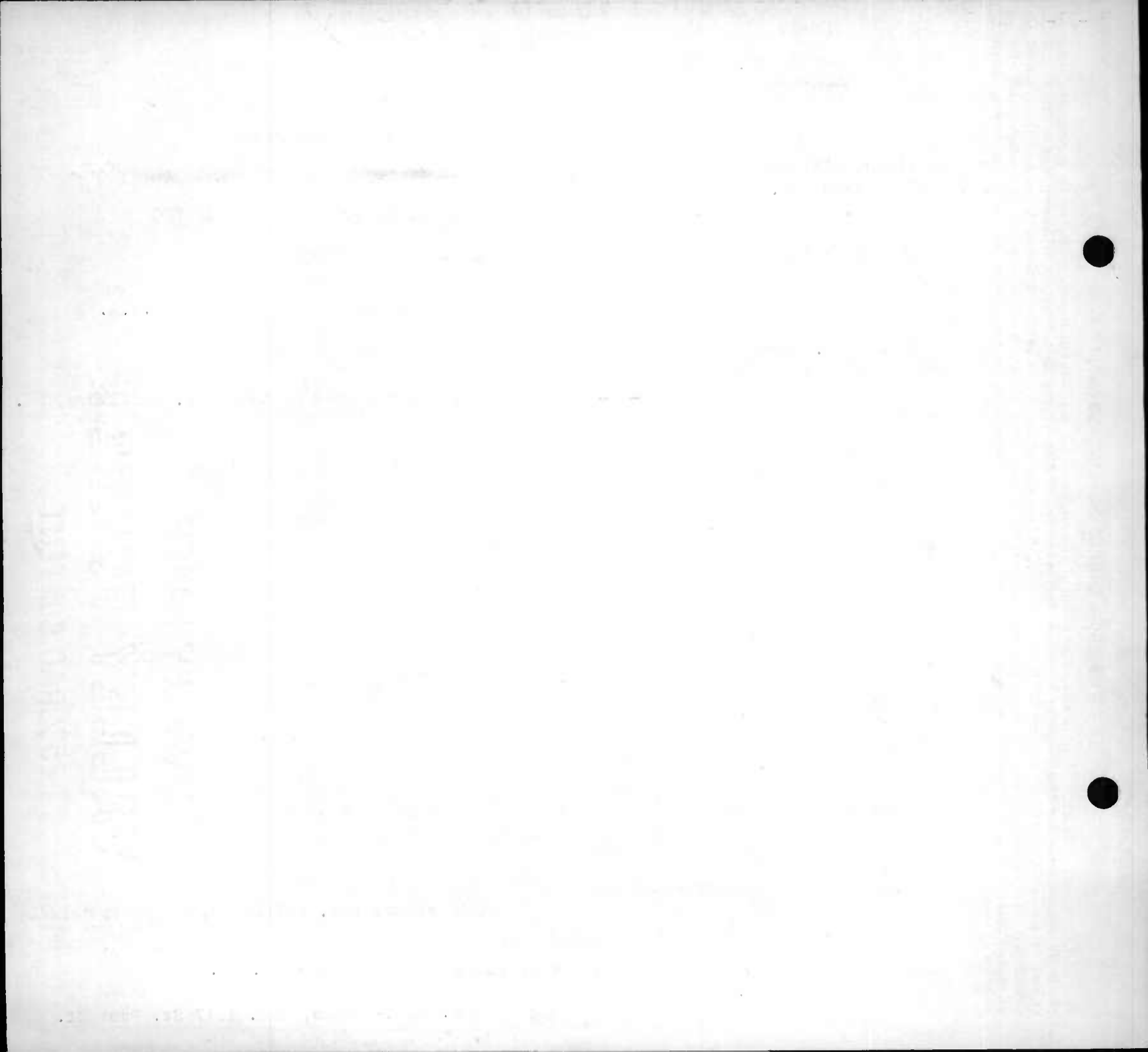
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 4463 | |
|---|----------------------|--|--|--|--|
| BIRTH NO. 67 4463 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. constantine | | 1. NAME OF DECEASED (Type or Print) Constance Picarello | | 2. DATE AND HOUR OF DEATH May 5-67 12:00 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 35 Church Home Hosp | | C. CITY OR TOWN Balto. | | D. STREET ADDRESS (If rural, give location) 422 S. Eden St. 3-02 | |
| 5. SEX F. | 6. RACE W. | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH May 19-1886 | 9. AGE (In years last birthday) 80 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home | | 10B. KIND OF BUSINESS OR INDUSTRY None | 11. BIRTH PLACE (State or foreign country) Italy | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Joseph Spina | | 14. MOTHER'S MAIDEN NAME Vanzino | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 220057661 | 17. INFORMANT ADDRESS Amalia Picarillo 422 S. Eden St. | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 720.01+260X | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | (A) DUE TO ARTERIOSCLEROSIS, Generalized | | ? years | |
| ANTECEDENT CAUSES | | (B) DUE TO ARTERIOSCLEROTIC HEART Dis. | | ? YEARS | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) | | | |
| II | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetes Mellitus | | 20 years | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that (I) (this hospital) attended the deceased from 6/25 1965 to 5/5 1967, that (I) (we) last saw the deceased alive on 5/5 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE [Signature] | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | 23B. DATE SIGNED 5/6/67 | | |
| 23C. PHYSICIAN'S NAME (Type) IRVIN B. KAPLAN, M.D. | | 23D. ADDRESS 129 S. Broadway Balto Md 21231 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | 24B. DATE MAY 9 1967 | 24C. NAME OF CEMETERY or CREMATORY HOLY REDEEMER CEM. | | 24D. LOCATION City, town, or county) 4430 BELAIR RD MD | |
| 25A. DATE REC'D BY HEALTH DEPT. MAY 8 1967 | | 25B. NAME OF REGISTRAR Robert E. [Signature] | | 25C. FUNERAL DIRECTOR ADDRESS AIRTEL BROS INC 1800 E LOYBARO ST | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|---|--|--|--|
| BIRTH NO. 67 4464 | | BALTIMORE CITY HEALTH DEPARTMENT | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH X Registered No. 67 4464 | |
| 1. NAME OF DECEASED (Type or Print) ERVIN, LORENA | | 2. DATE AND HOUR OF DEATH 5/4/67 1:35 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Baltimore City Hospitals
4940 Eastern Ave.
Baltimore, Maryland # 21224 | | A. STATE B. COUNTY
Maryland Baltimore Co. | |
| 5. SEX Female | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
53-00 | |
| 6. RACE White | | D. STREET ADDRESS (If rural, give location)
119 Edgewater Apts 21221 005 | |
| 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | | 8. DATE OF BIRTH 9-12-90 | |
| 9. AGE (In years last birthday) 76 | | 10. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 11. BIRTHPLACE (State or foreign country) Pennsylvania | |
| 10B. KIND OF BUSINESS OR INDUSTRY | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME William R. Gorley | | 14. MOTHER'S MAIDEN NAME Rhoda Turner | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 234-01-2962D | |
| 17. INFORMANT BCH: Records 4940 Eastern Ave. Baltimore, Md. | | ADDRESS #21224 | |
| 18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Rheumatic Heart Disease | | INTERVAL BETWEEN ONSET AND DEATH
24 hrs | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from May 3 19 67 to May 4 19 67, that (1) (we) last saw the deceased alive on May 4 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE Mary Ann Sullivan | | 23B. DATE SIGNED 5/4/67 | |
| 23C. PHYSICIAN'S NAME (Type) Mary Ann Sullivan | | 23D. ADDRESS 4940 Eastern Ave. Baltimore, Maryland #21224 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 5/8/67 | |
| 24C. NAME OF CEMETERY or CREMATORY Arborvale Cemetery | | 24D. LOCATION (City, town, or county) (State) Arborvale, W. Va. | |
| 25A. DATE REC'D BY HEALTH DEPT. MAY 8 1967 | | 25B. NAME OF REGISTRAR Wm. Cook-Brooks, Inc. 1217 St. Paul St. | |
| 25C. FUNERAL DIRECTOR | | 25D. ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | | | | | | | | | Registered No. 67 4465 |
|---|-------------------------|---|-------------------------------------|--|----------------------------|--|-----------------------------|---------|--|-------------------------------|
| BIRTH NO. 67 4465 | | | | | | | | | | |
| M.E. CASE NO. | | | | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) BIZIEWSKI | | 2. DATE AND HOUR OF DEATH
MAY 6, 1967 1 30 A.M. | | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD. B. COUNTY Baltimore Co. | | | | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
SINAI HOSPITAL OF BALTO. | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE TOWSON 21204 | | | | | | | | |
| | | D. STREET ADDRESS (If rural, give location)
400 WOODBINE AVE 53-00 | | | | | | | | |
| 5. SEX
FEMALE | 6. RACE
CAUC. | 7. MARRIED, NEVER MARRIED, WIDOWED, <u>DIVORCED</u> (Specify) | 8. DATE OF BIRTH
10/10/05 | 9. AGE (In years last birthday)
61 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Bookkeeper | | 10B. KIND OF BUSINESS OR INDUSTRY
Clothes | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | |
| 13. FATHER'S NAME
John H. Baier | | 14. MOTHER'S MAIDEN NAME
Catherine Finnerty | | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
213-05-5258 | | 17. INFORMANT
Michele Lilly | | ADDRESS
732 Bridgeport Ave Towson 4, Md | | | | |
| 18. 443 X 1 | | CAUSE OF DEATH | | | | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | (A) CEREBRAL HEMORRHAGE
DUE TO | | | | | | 3 DAYS. | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) HYPERTENSIVE CARDIOVASCULAR DISEASE
DUE TO | | | | | | ? | | |
| | | (C) | | | | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | | |
| 22. I certify that (I) <u>(this hospital)</u> attended the deceased from MAY 2 19 67 to MAY 6 19 67 , that (I) <u>(we)</u> last saw the deceased alive on MAY 6 19 67 and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(we)</u> <u>(did)</u> (did not) view the body after death. | | | | | | | | | | |
| 23A. SIGNATURE
Melvyn B. Lewis | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED
MAY 6, 1967 | | | | |
| 23C. PHYSICIAN'S NAME (Type)
MELVYN B. LEWIS | | 23D. ADDRESS
M.D. SINAI HOSPITAL OF BALTO. | | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
5-9-67 | | 24C. NAME OF CEMETERY or CREMATORY
Prospect Hill | | 24D. LOCATION (City, town, or county) (State)
Towson, Md | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 8 1967 | | 25B. NAME OF REGISTRAR
Wm Cook | | 25C. FUNERAL DIRECTOR
Brooks Towson | | ADDRESS
7604 TOWSON, MD | | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 67 4466 | | BALTIMORE CITY HEALTH DEPARTMENT | | 67 4466 | |
|---|------------------|---|--|--|---|
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | Registered No. | |
| 1. NAME OF DECEASED
(Type or Print) Evelyn Earp Parlett | | | 2. DATE AND HOUR OF DEATH
5-5-67 1:15 P M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
90 Long Green Nursing Home
Melrose Ave. | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY Baltimore Co.
C. CITY OR TOWN (If outside city limits, write RURAL and give township) 53-00
D. STREET ADDRESS (If rural, give location)
210 Roger Forge Rd. 21212 | | |
| 5. SEX
F. | 6. RACE
Cauc. | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widowed | 8. DATE OF BIRTH
1-20-1907 | 9. AGE (In years last birthday)
60 | If Under 1 Yr. Months Days (f Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Teacher | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Baltimore, Md. | |
| 13. FATHER'S NAME
Henry Shelton Earp | | | 14. MOTHER'S MAIDEN NAME
Maude Richardson | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No. | | 16. SOCIAL SECURITY NO.
214-40-8315 | | 17. INFORMANT
H. Shelton Earp, Baltimore, Md. 21212 | |
| 18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, assthenia, etc. It means the disease, injury or complication which caused death.)
Circosis (Lungs) 2 years
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (the hospital) attended the deceased from 1954 to May 5 1967, that (I) (we) last saw the deceased alive on May 5 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Newland Edward Day M.D. | | | 23B. DATE SIGNED
May 7, 1967 | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> |
| 23C. PHYSICIAN'S NAME (Type)
Newland Edward Day M.D. | | | 23D. ADDRESS
4-E-33rd ST Baltimore Md. | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
5-8-67 | | 24C. NAME OF CEMETERY or CREMATORY
Lorraine Park | |
| 24D. LOCATION
Woodlawn Balto. Md. | | 24E. NAME OF REGISTRAR
Wm. Cook-Brooks Towson, Towson, Md. 21204 | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 8 1967 | | 25B. NAME OF REGISTRAR
Wm. Cook-Brooks Towson, Towson, Md. 21204 | | 25C. FUNERAL DIRECTOR ADDRESS | |

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1971

FUNERAL DIRECTOR: IMPORTANT

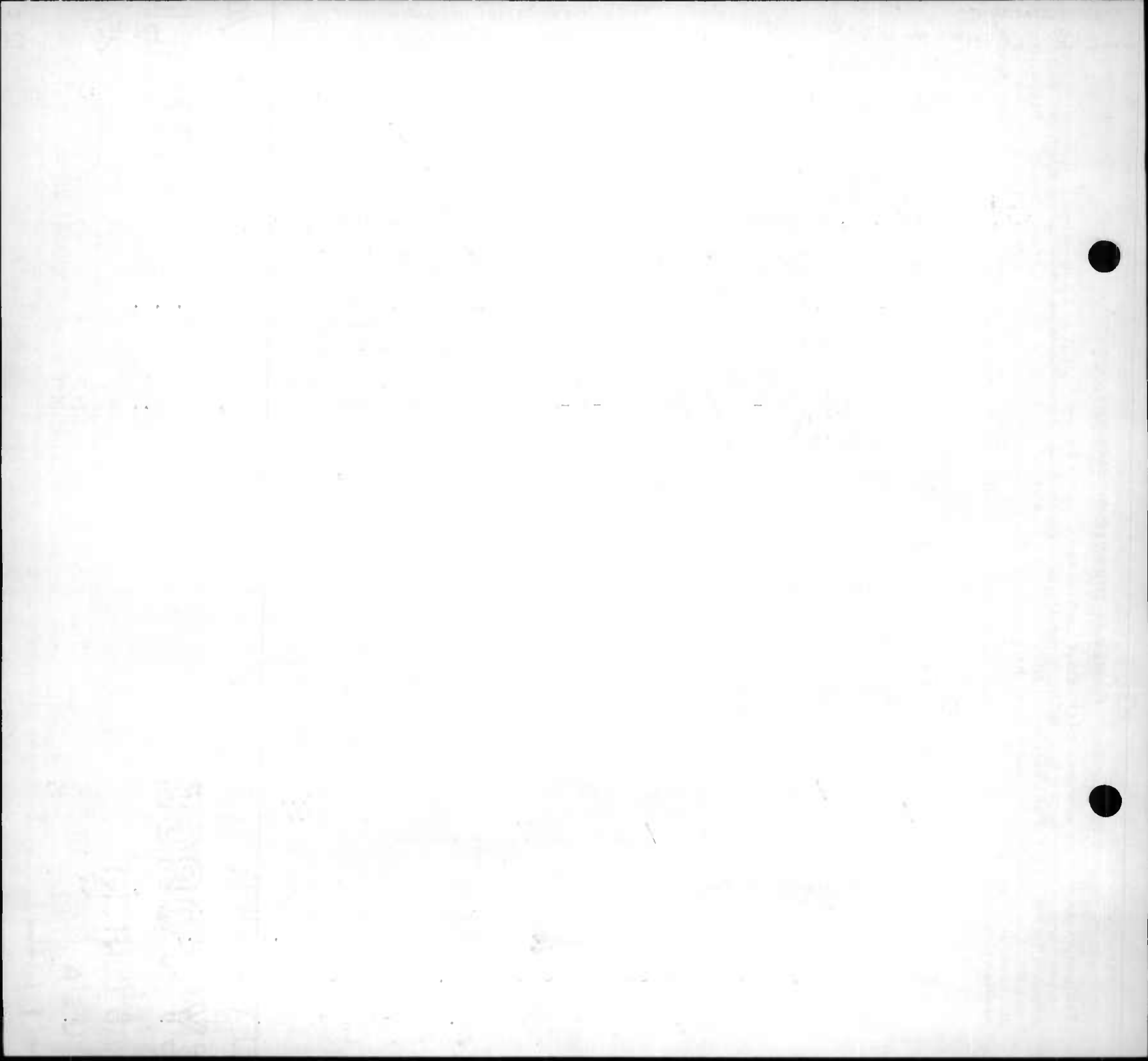
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 67 4467 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 4467 | |
|---|---------------------|---|--|---|--|
| M.E. CASE NO. | | | CERTIFICATE OF DEATH | | |
| 1. NAME OF DECEASED
(Type or Print) VIAR, JOSEPH EDWARD | | | 2. DATE AND HOUR OF DEATH
MAY 4, 1967 9:30 P.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Veterans Administration Hospital
3900 Loch Raven Boulevard
Baltimore, Maryland 21218 | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE B. COUNTY
Maryland
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
1839 Bolton Street | | |
| 5. SEX
Male | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married | 8. DATE OF BIRTH
1/25/91 | 9. AGE (In years last birthday)
76 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Papermill | | 10B. KIND OF BUSINESS OR INDUSTRY
Papermill | 11. BIRTHPLACE (State or foreign country)
Grottoes, Virginia | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. |
| 13. FATHER'S NAME
James Viar | | | 14. MOTHER'S MAIDEN NAME
Sally Rounds | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
Yes 6/23/18 - 12/15/18 | | 16. SOCIAL SECURITY NO.
220-48-4385 | 17. INFORMANT ADDRESS
Veterans Administration Hospital Records
3900 Loch Raven Boulevard, Balto., Md 21218 | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
331X I
CAUSE OF DEATH
(A) Cerebral hemorrhage, massive
DUE TO

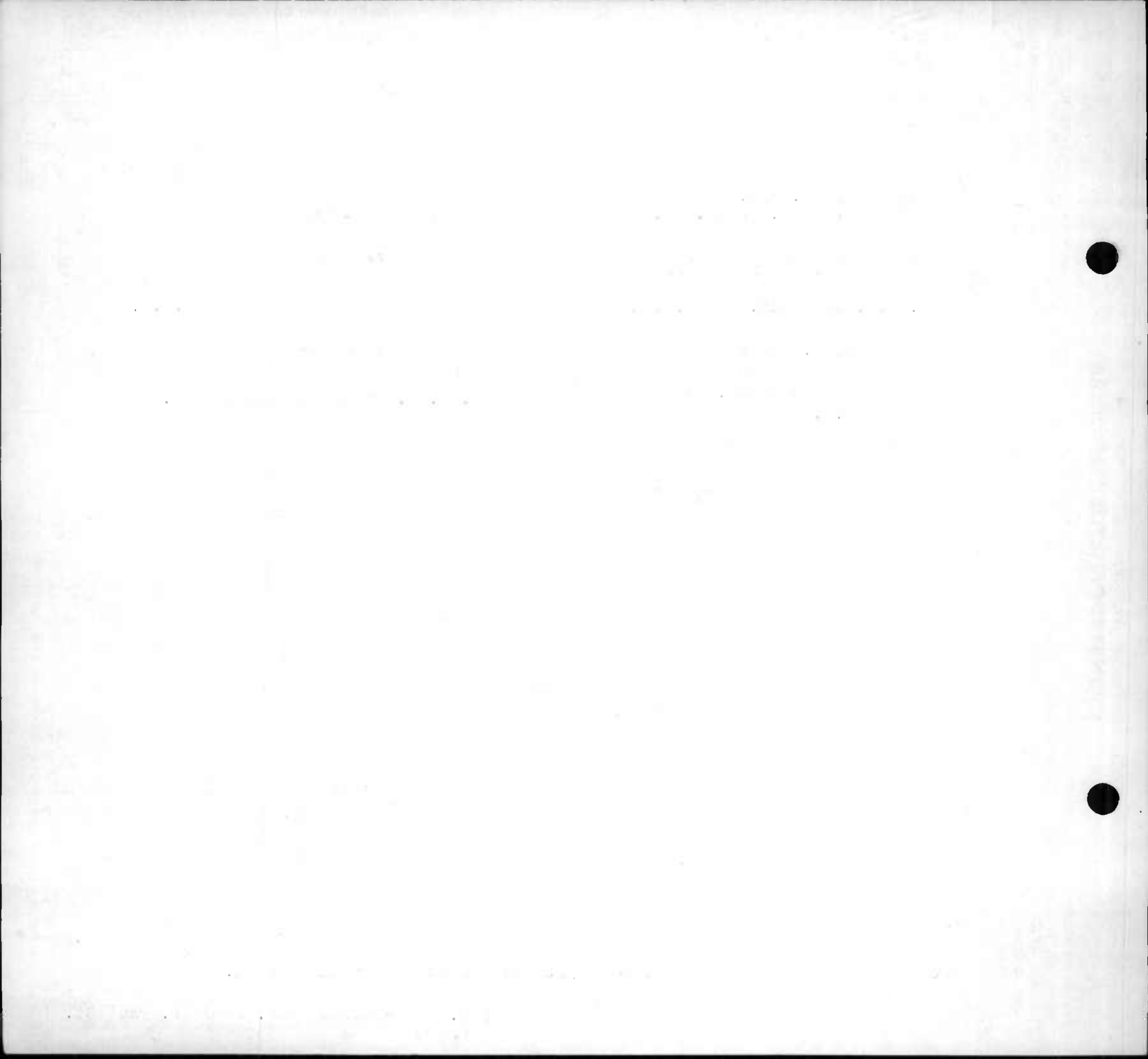
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No)
Yes | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that (Y) (this hospital) attended the deceased from May 3rd 19 67 to May 4th 19 67, that (N) (we) last saw the deceased alive on May 4th 19 67 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (N) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Domingo A. Garcia | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
May 5, 1967 |
| 23C. PHYSICIAN'S NAME (Type) | | | 23D. ADDRESS
Veterans Administration Hospital
3900 Loch Raven Blvd., Balto., Md 21218 | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | 24B. DATE
5/8/67 | 24C. NAME OF CEMETERY or CREMATORY
Baltimore National Cem. | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 8 1967 | | 25B. NAME OF REGISTRAR
R. B. E. Talbott | | 25C. FUNERAL DIRECTOR ADDRESS
Wm. Cook-Brooks, Inc. 1217 St. Paul St. | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Certificate of Death | | Registered No. 67 4468 | |
|---|---|--|--|--|--|--|--|
| BIRTH NO. 67 4468 | | | | | | | |
| M.E. CASE NO. | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) FRANK EDWIN DAVIS | | | | 2. DATE AND HOUR OF DEATH
MAY 5, 1967 8 P M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Preston Apts. Apt. 4B
218 Preston St. Balto. Md. 21202 | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | | | |
| | | | | D. STREET ADDRESS (If rural, give location)
218 Preston Street | | | |
| 5. SEX
Male | 6. RACE
Caucasian | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married | | 8. DATE OF BIRTH
March 6, 1887 | 9. AGE (In years last birthday)
90 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Col. U.S. Army Ret. | | 10B. KIND OF BUSINESS OR INDUSTRY
U.S. Army | | 11. BIRTHPLACE (State or foreign country)
Ohio | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Wilbur E. Davis | | | | 14. MOTHER'S MAIDEN NAME
Frances Barnum | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
Yes Spanis -Amer. War | | 16. SOCIAL SECURITY NO.
216-46-1300 | | 17. INFORMANT ADDRESS
Col. W. E. Davis 218 Preston St. | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
Pneumonia | | | | (A) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH
Days | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Emphysema | | | | (B) DUE TO | | Years | |
| | | | | (C) | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
ASCVD | | | | | | Years | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (1) (this hospital) attended the deceased from July 1965 to May 5 1967 , that (1) (we) last saw the deceased alive on May 5 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
RK Gundry M.D. | | | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
5-8-67 | |
| 23C. PHYSICIAN'S NAME (Type)
RK Gundry M.D. | | | | 23D. ADDRESS
2 W University Pkwy
Balt Md 21218 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
5/9/67 | | 24C. NAME OF CEMETERY or CREMATORY
Baltimore National Cemetery | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 8 1967 | | 25B. NAME OF REGISTRAR
J. E. Fabela | | 25C. FUNERAL DIRECTOR ADDRESS
Wm. Cook-Brooks, Inc. 1217 St. Paul St. | | | |



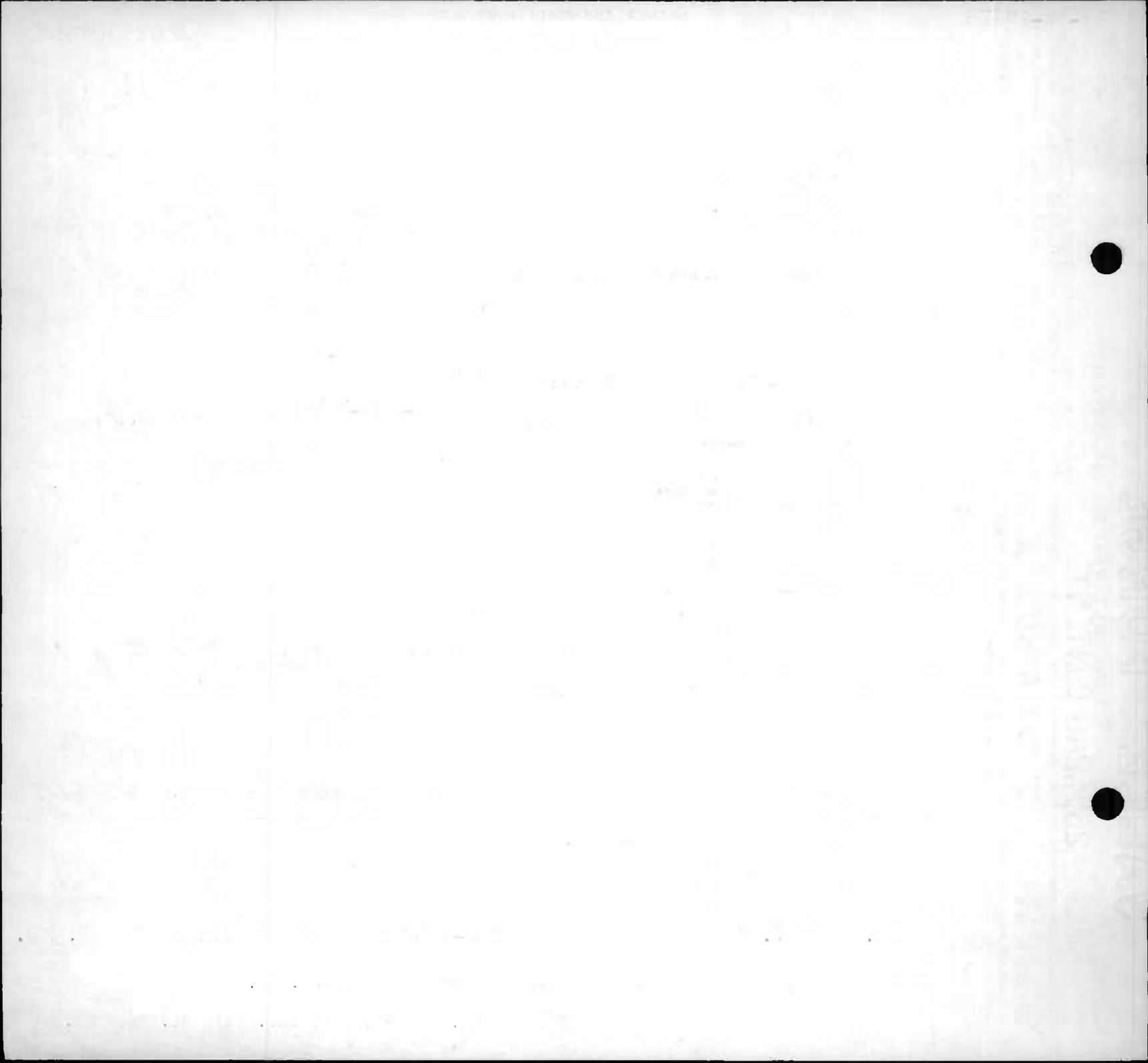
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

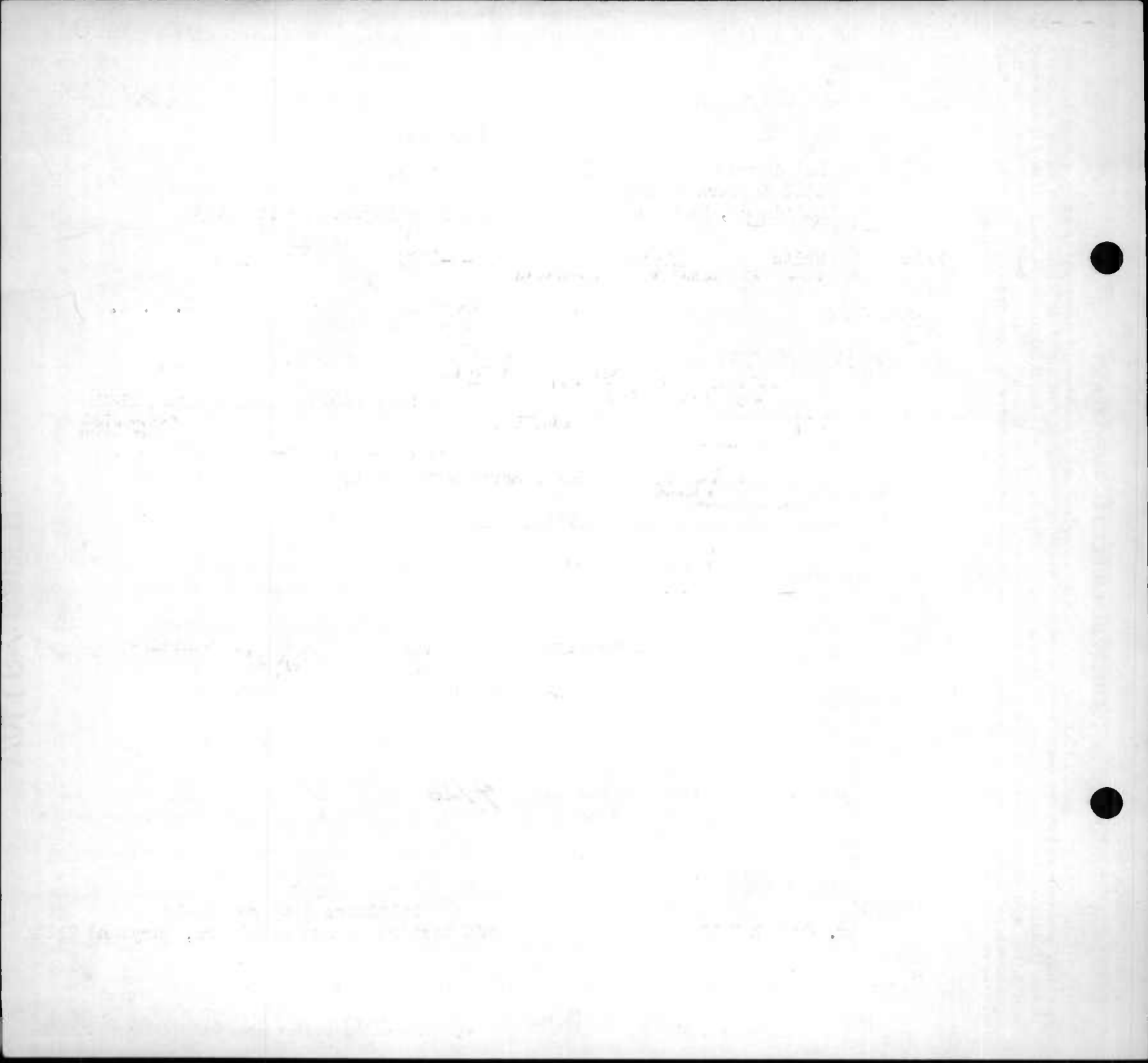
| | | | | | |
|--|-------------------|--|------------------------------|---|---|
| BIRTH NO. 67 4469 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 4469 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) MARGARET BLACKWELL | | 2. DATE AND HOUR OF DEATH 5 May 1967 11 P M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE X | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 26-36 | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 31 BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND | | D. STREET ADDRESS (If rural, give location) 1231 GREGORY WAY | | | |
| 5. SEX Female | 6. RACE Caucasian | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 5 Sept 1907 | 9. AGE (In years last birthday) 59 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) North Carolina | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME George | | 14. MOTHER'S MAIDEN NAME Stella Cole | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. ? | | 17. INFORMANT ADDRESS RECORDS-BCH-4940 EASTERN AVENUE | |
| 18. 527.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH (A) Chronic Obstructive Pulmonary Disease | | INTERVAL BETWEEN ONSET AND DEATH 7 years | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO | | | |
| (C) DUE TO | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (this hospital) attended the deceased from 1 May 1967 to 5 May 1967, that (I) last saw the deceased alive on 5 May 1967 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Alan J. Barnes | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 5 May 1967 | |
| 23C. PHYSICIAN'S NAME (Type) DR. ALAN J. BARNES | | 23D. ADDRESS M.D. BCH-4940 EASTERN AVENUE, BALTIMORE, MD. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 5/9/67 | | 24C. NAME OF CEMETERY or CREMATORY Baltimore National Cemetery Balto. Md. | |
| 24D. LOCATION (City, town, or county) (State) | | 25A. DATE RECEIVED BY HEALTH DEPT MAY 8 1967 | | 25B. NAME OF REGISTRAR Robert E. Fairley | |
| 25C. FUNERAL DIRECTOR Wm. Cook-Brooks, Inc. 1217 St. Paul St. | | ADDRESS | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 4470 | |
|---|---------------|--|----------------------------|--|---|
| BIRTH NO. 67 4470 | | M.E. CASE NO. | | MAY 6 1967 | |
| 1. NAME OF DECEASED
(Type or Print) Charles Mitchell | | 2. DATE AND HOUR OF DEATH
5/6/67 9:00 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
31 Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland 21224 | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Baltimore
C. CITY OR TOWN (If outside city limits, write RURAL and give township) 24-04
D. STREET ADDRESS (If rural, give location)
1543 Covington Street 21230 | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH 11-3-1885 | 9. AGE (In years last birthday) 81 | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HUCKSTER | | 10B. KIND OF BUSINESS OR INDUSTRY SELF EMPLOYED | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | 13. FATHER'S NAME JOHN W. MITCHELL | | | |
| 14. MOTHER'S MAIDEN NAME JULIA STAFFORD | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | |
| 16. SOCIAL SECURITY NO. NONE | | 17. INFORMANT ADDRESS RECORDS: BCM 4940 Eastern Avenue 21224 | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
493X I
RESPIRATORY INSUFFICIENCY
PNEUMONIA
INTERVAL BETWEEN ONSET AND DEATH 2 weeks | | CAUSE OF DEATH
(A) DUE TO
(B) DUE TO
(C) DUE TO | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Chronic Obstructive Pulmonary Disease 20 yrs | | 19A. DATE OF OPERATION 0 | | | |
| 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 4/26 1967 to 5/6 1967, that (I) (we) last saw the deceased alive on 5/6 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Judith Hall | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 5/6/67 | |
| 23C. PHYSICIAN'S NAME (Type) Dr. Judith Hall | | 23D. ADDRESS Baltimore City Hospitals
4940 Eastern Avenue Baltimore, Maryland 21224 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE MAY 9/1967 | | 24C. NAME OF CEMETERY OR CREMATORY LOUDON PARK CEMETERY BALTO. CITY MD. | |
| 24D. LOCATION (City, town, or county) (State) | | 25A. DATE REC'D BY HEALTH DEPT. MAY 8 1967 | | 25B. NAME OF REGISTRAR R. G. E. FALGOUT | |
| 25C. FUNERAL DIRECTOR Wm. A. COOK | | ADDRESS BROOKS INC. 1217 St. PAUL ST. | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | Registered No. <u>67 4471</u> | |
|---|-------------------------|---|---|--|---|--|---|
| BIRTH NO. <u>67 4471</u> | | M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) <u>PATTEN, Walter NMI</u> | | 2. DATE AND HOUR OF DEATH
<u>5/7/67</u> <u>3:50</u> P M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<u>Veterans Administration Hospital</u>
<u>3900 Loch Raven Boulevard</u>
<u>Baltimore, Maryland 21218</u> | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <u>Maryland</u>
B. COUNTY

C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>Baltimore</u>
D. STREET ADDRESS (If rural, give location)
<u>331 S. Ellwood Avenue</u> | | | |
| 5. SEX
<u>Male</u> | 6. RACE
<u>White</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)
<u>Married</u> | 8. DATE OF BIRTH
<u>11/2/16</u> | 9. AGE (In years last birthday)
<u>50</u> | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Musician</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>New York, N.Y.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> |
| 13. FATHER'S NAME
<u>Jack Patten</u> | | | 14. MOTHER'S MAIDEN NAME
<u>Mae Coe</u> | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give year or dates of service)
<u>Yes</u> <u>2/28/41 - 9/4/45</u> | | | 16. SOCIAL SECURITY NO.
<u>051-12-4858</u> | | 17. INFORMANT ADDRESS
<u>Veterans Administration Hospital Records</u>
<u>3900 Loch Raven Blvd., Balto., Md. 21218</u> | | |
| 18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)
<u>Bronchogenic Carcinoma with metastases to Cerebellum</u>
INTERVAL BETWEEN ONSET AND DEATH
<u>1 year</u> | | | | | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION
<u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<u>Yes</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
<u>Yes</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initially medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>April 27th</u> 19 <u>67</u> to <u>May 7th</u> 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>May 7th</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
<u>David N. Marine</u> | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
<u>May 8, 1967</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>DAVID N. MARINE</u> | | | | 23D. ADDRESS
M.D. <u>V A Hospital</u>
<u>3900 Loch Raven Blvd., Balto., Md 21218</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | 24B. DATE
<u>5-10-67</u> | | 24C. NAME of CEMETERY or CREMATORY
<u>PINELAWN NATIONAL CEM NEW YORK</u> | | 24D. LOCATION (City, town, or county) (State)
<u>NEW YORK</u> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>MAY 8, 1967</u> | | 25B. NAME OF REGISTRAR
<u>John E. Johnson</u> | | 25C. FUNERAL DIRECTOR
<u>JOHN M. WEBER & SONS INC 401 S. CHESTER ST.</u> | | ADDRESS | |

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>67 4472</u> | |
|---|-------------------------|---|--|---|---|
| BIRTH NO. <u>67 4472</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) <u>Webster Hendricks Brown</u> | | 2. DATE AND HOUR OF DEATH
<u>May 5, 1967</u> M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <u>Md.</u>
B. COUNTY <u>Baltimore</u> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>00</u>
<u>1034 N. Calvert Street</u> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>Baltimore</u>
D. STREET ADDRESS (If rural, give location)
<u>1034 N. Calvert Street</u> | | | |
| 5. SEX
<u>Male</u> | 6. RACE
<u>White</u> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<u>Married</u> | 8. DATE OF BIRTH
<u>Nov. 11, 1906</u> | 9. AGE (In years last birthday)
<u>60</u> | If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Physician</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>Indiana</u> | |
| 13. FATHER'S NAME
<u>Dr. Louis Emmitt Brown</u> | | 16. SOCIAL SECURITY NO.
<u>274-10-1717</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>Yes</u>
<u>World 11</u> | | 17. INFORMANT
<u>Jessie Hendricks</u> | | ADDRESS
<u>Mrs. Annabella R. Brown as above</u> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)
<u>163X1</u>
<u>CARCINOMA OF LUNG</u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>2 YEARS</u> | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) <u>CORONARY ARTERY DISEASE 5 YEARS</u>
(C) <u>VENTRICULAR FIBRILLATION TERMINAL</u> | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
<u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<u>YES</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>1950</u> to <u>MAY 4</u> 19 <u>67</u> .
that (I) (we) last saw the deceased alive on <u>MAY 4</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. <u>700 PM</u> | | | | | |
| 23A. SIGNATURE
<u>Ralph G. Hills</u> | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
<u>5/7/67</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>RALPH G. HILLS</u> | | 23D. ADDRESS
<u>18 E EAGER ST. BALTO 2 MD</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Cremation</u> | | 24B. DATE
<u>May 8 1967</u> | | 24C. NAME OF CEMETERY or CREMATORY
<u>Greenmount</u> | |
| 24D. LOCATION (City, town, or county) (State)
<u>Baltimore, Md.</u> | | 25A. DATE REC'D BY HEALTH DEPT.
<u>MAY 8 1967</u> | | | |
| 25B. NAME OF REGISTRAR
<u>William J. Jackson + Sons North + Pa. Ave</u> | | 25C. FUNERAL DIRECTOR ADDRESS | | | |

1 BENEFICIAL FIBRILLATION TENDS
TO INCREASE WITH AGE
AND WITH EXERCISE

YES YES

20 MAY 11 1967
JES

20 MAY 11 1967

✓
RABIN G. HIRSH 12 E EAGER ST. BOSTON MA 02114
2/7/67

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | | | Registered No. 67 4473 | |
|--|--|---|---|--|---|
| BIRTH NO. 67 4473 | | | | | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED
(Type or Print) KITSON, CATHERINE | | 2. DATE AND HOUR OF DEATH
May 7, 1967 2:20 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
North Chas Gen Hosp
49 27 | | A. STATE Maryland
B. COUNTY 26-02 | | | |
| (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
5523 Daywalt Ave. Baltimore | | | |
| | | D. STREET ADDRESS (If rural, give location)
5523 Daywalt Ave | | | |
| 5. SEX 69 F | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH
1/8/98 | 9. AGE (In years last birthday)
69 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HW | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Baltimore, Md. | |
| 13. FATHER'S NAME
August Rossback | | 14. MOTHER'S MAIDEN NAME
Mamie Appleg | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
— | | 17. INFORMANT ADDRESS
Chart | |
| 18. 54101 | | CAUSE OF DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | (A) Bilateral Bronchopneumonia
—hypostatic. | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B)
(C)
 | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
4/14/67 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
Bleeding duodenal ulcer | | 20A. AUTOPSY? (Yes or No)
Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 4/15 1967 to 5/7 1967, that (I) (we) last saw the deceased alive on 5/7 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
A. Appleg | | M.O. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
5/7/67 | |
| 23C. PHYSICIAN'S NAME (Type)
DR. RELLE | | 23D. ADDRESS
M.O. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
5/11/67 | | 24C. NAME of CEMETERY or CREMATORY
Loudon Park Cemetery | |
| 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 8 1967 | | 25B. NAME OF REGISTRAR
John A. Moran, Inc. | | 25C. FUNERAL DIRECTOR ADDRESS
3000 E. Baltimore St. | |

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2/1/12

2/1/12 1/2 1/2 1/2 1/2

4/10/07 1/2 1/2 1/2 1/2

DR. REICE
1/2 1/2 1/2 1/2

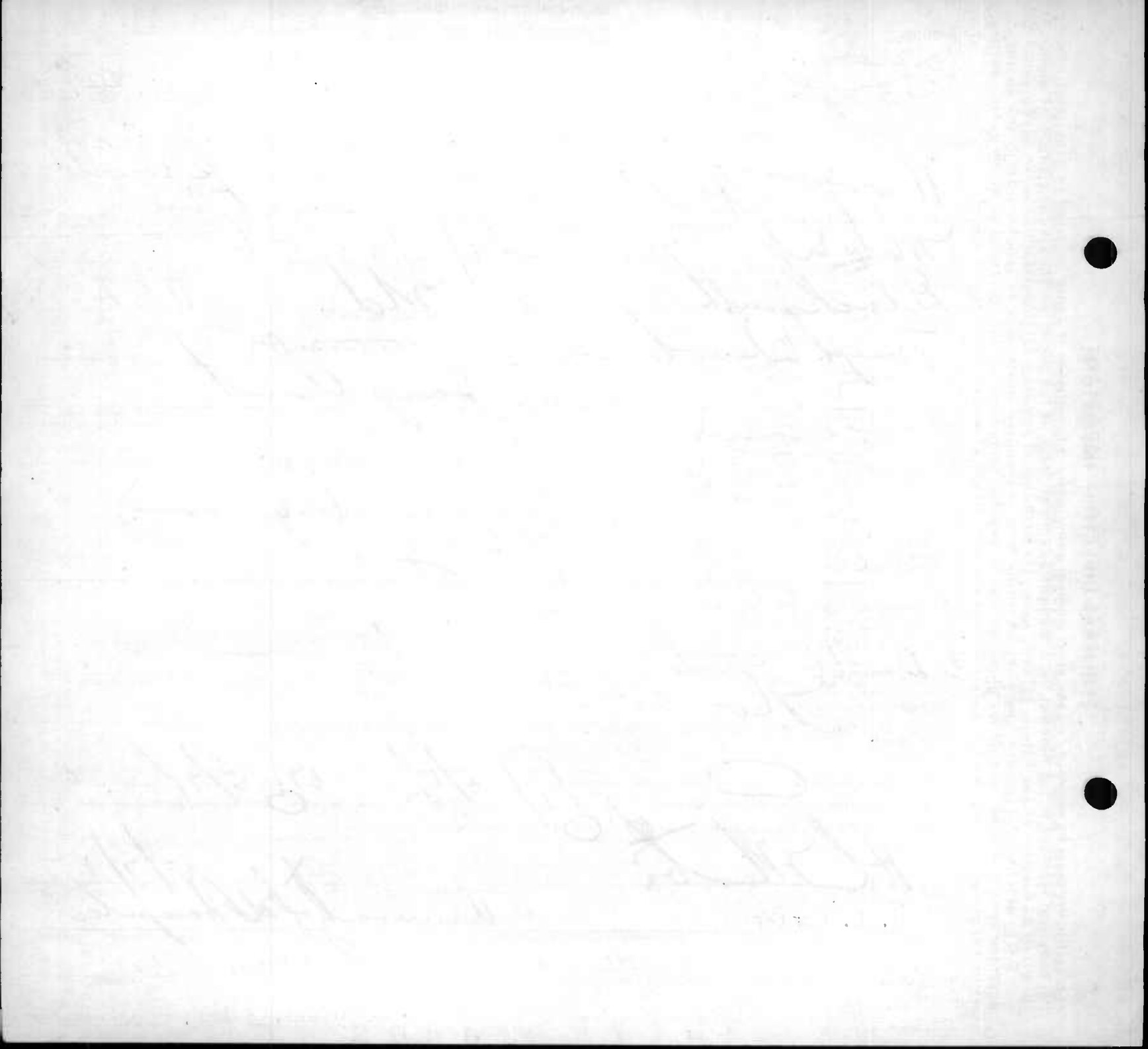
2/4/12 ✓

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 67 4474 | | | | CITY OF BALTIMORE DEPARTMENT | | REGISTERED NO. 67 4474 | |
|--|--|---|--|---|--|---|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) <u>Joseph STEVEN W. SOLOWSKY</u> | | | | 2. DATE AND HOUR OF DEATH
<u>5/7/67 1:22 PM</u> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<u>University Hospital Baltimore</u> | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <u>Md.</u> B. COUNTY <u>Baltimore</u> | | | |
| 5. SEX <u>Male</u> 6. RACE <u>White</u> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Married</u> | | | | 8. DATE OF BIRTH <u>8/12/1910</u> 9. AGE (in years last birthday) <u>56</u> | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Blacksmith</u> | | | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Md.</u> | | 11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Joseph Wesołowski</u> | | | | 14. MOTHER'S MAIDEN NAME <u>unknown</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>yes WW77</u> | | | | 16. SOCIAL SECURITY NO. <u>213-07-3375</u> | | 17. INFORMANT <u>Hoops Char</u> ADDRESS | |
| 18. <u>163X I</u> CAUSE OF DEATH | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)
<u>Pneumonia</u> | | | | (A) DUE TO | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
<u>Cappnomal (squamous)</u> | | | | (B) DUE TO | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
<u>of lung</u> | | | | (C) | | | |
| 19A. DATE OF OPERATION <u>Dec '66</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Hoops Biopsy</u> | | 20A. AUTOPSY? (Yes or No) <u>No</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>No</u> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>3/6/67</u> to <u>5/7/67</u> that (I) (we) last saw the deceased alive on <u>5/7/67</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>H. L. Marter</u> | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <u>5/7/67</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>H. L. Marter</u> | | | | 23D. ADDRESS <u>University of Md Hospital</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>5/11/67</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery</u> | | 24D. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>MAY 8 1967</u> | | 25B. NAME OF REGISTRAR <u>John A. Moran, Inc.</u> | | 25C. FUNERAL DIRECTOR ADDRESS <u>3000 E. Baltimore St</u> | | | |



The body of Edward Vierecht has been released as Not Med by Dr. Linthicum

of Medical Examiner Office
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|-----------|---|-----------------------------|--|---|
| BIRTH NO. 67 4475 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 4475 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | 2. DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED
(Type or Print) Edward Vierecht (Vierecht) | | 5/8/67 | | 15:30 A. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
Johns Hopkins Hospital | | A. STATE Md.
B. COUNTY Balts. Co | | | |
| (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore Md. #3453-00 | | | |
| D. STREET ADDRESS (If rural, give location)
9502 Powder Horn Lane | | | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED
WIDOWED DIVORCED (specify)
widowed | 8. DATE OF BIRTH
5/27/10 | 9. AGE (In years last birthday)
56 | 10. If Under 1 Yr. Months Days Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
self employed | | 10B. KIND OF BUSINESS OR INDUSTRY
Restaurant | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 13. FATHER'S NAME
Charles Edward Vierecht | | 14. MOTHER'S MAIDEN NAME
Catherine (Pecker) Frecker | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
yes WW 2 | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Edward C. Vierecht, Jr. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
177X-1904.9
ADENOCARCINOMA of the prostate | | CAUSE OF DEATH
(A) DUE TO
(B) DUE TO
(C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH
6 months | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
2/28/67 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
Fractured Femur | | 20A. AUTOPSY? (Yes or No)
NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)
(APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from 5/7/67 to 5/8/67 that (1) (we) last saw the deceased alive on 5/7/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Henry H. Bohlman, M.D. | | 23B. DATE SIGNED
5/8/67 | | | |
| 23C. PHYSICIAN'S NAME (Type)
Henry H. Bohlman M.D. | | 23D. ADDRESS
Johns Hopkins | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
cremation | | 24B. DATE
5-11-67 | | 24C. NAME OF CEMETERY or CREMATORY
Greenmount Crematorium | |
| 24D. LOCATION (City, town, or county)
Baltimore, Md. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 8 1967 | | 25B. NAME OF REGISTRAR
Robert E. Faldut | | 25C. FUNERAL DIRECTOR
Leonard J. Ruck, Inc Baltimore, Md. | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | | | | | Registered No. <u>67 4476</u> | |
|--|-------------------------|---|---|--|---|--|--|
| BIRTH NO.
<u>67 4476</u> | | M.E. CASE NO.
1. NAME OF DECEASED
(Type or Print) <u>Eugene J. Hammel</u> | | | | 2. DATE AND HOUR OF DEATH
<u>May 7, 1967</u> <u>1 0</u> P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<u>Union Memorial Hospital</u> | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <u>Md.</u>
B. COUNTY _____
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>
D. STREET ADDRESS (If rural, give location) <u>5430 Belair Road</u> | | | |
| 5. SEX
<u>male</u> | 6. RACE
<u>white</u> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<u>widowed</u> | 8. DATE OF BIRTH
<u>June 23, 1903.</u> | 9. AGE (In years last birthday)
<u>63</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Auditor</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>Fidelity Deposit Co.</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>George Hammel</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Barbara Michling</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>387095764</u> | | 17. INFORMANT
<u>Mrs. Thelma Hammel</u> | | ADDRESS (Same)
<u>(Same)</u> | |
| 18. <u>4 20 1</u> I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

<u>II</u>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | CAUSE OF DEATH
(A) DUE TO <u>Coronary Occlusion</u>
(B) DUE TO <u>Arteriosclerotic Heart Disease</u>
(C) _____ | | INTERVAL BETWEEN ONSET AND DEATH
<u>(24 hours)</u>
<u>1 yr</u> | |
| | | | | | | | |
| | | | | | | | |
| 19A. DATE OF OPERATION
<u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>JULY 1966</u> to <u>MAY 7 1967</u> , that (I) (we) last saw the deceased alive on <u>APRIL 1 1967</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
<u>Emmett P. Davis</u> M.D. | | | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
<u>5/8/67</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>EMMETT P. DAVIS</u> M.D. | | | | 23D. ADDRESS
<u>5317 BELAIR RD BALTIMORE MD 21206</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>5/11/67.</u> | | 24C. NAME of CEMETERY or CREMATORY
<u>New Cathedral Cemetery</u> | | 24D. LOCATION (City, town, or county) (State)
<u>Baltimore, Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>MAY 8 1967</u> | | 25B. NAME OF REGISTRAR
<u>Robert E. Fisher, MA</u> | | 25C. FUNERAL DIRECTOR
<u>Leonard J. Ruck Inc Baltimore, Md.</u> ADDRESS | | | |

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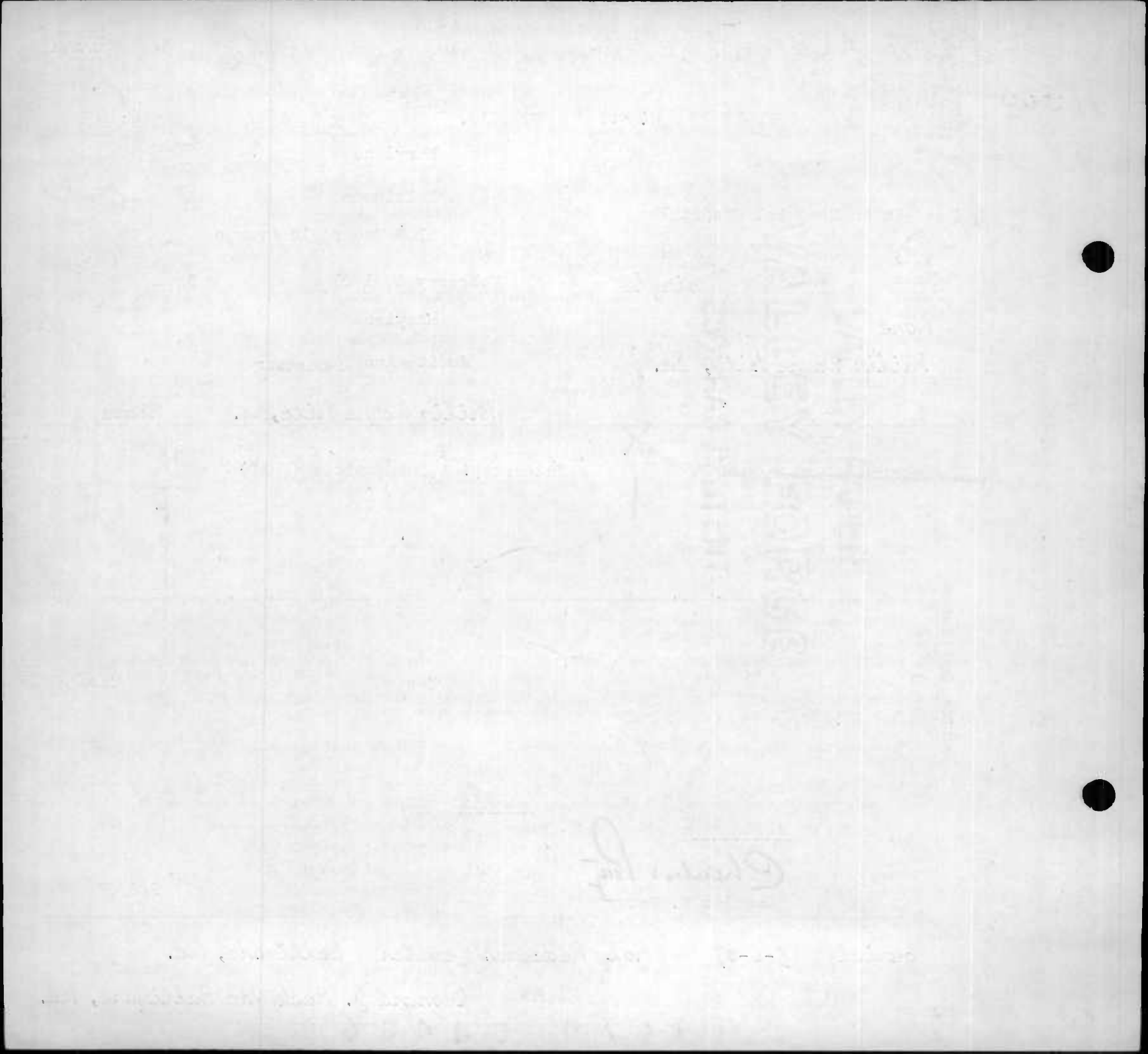
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REGISTERED NO. 67 4477 | |
|--|-------------------|---|--------------------------------|---|---|
| BIRTH NO. 67 4477 | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) HENRY CONRAD HENSCHEN, JR. | | | |
| 2. DATE AND HOUR OF DEATH | | MAY 7 1967 4:27 P. M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| CERTIFICATE AMENDED
HOSPITAL OR INSTITUTION
2710 Manhattan Avenue
5-15-67 | | A. STATE
Maryland.
B. COUNTY
Baltimore.
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location)
2710 Manhattan Ave. | | | |
| 5. SEX
Male. | 6. RACE
White. | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married. | 8. DATE OF BIRTH
12/12/1893 | 9. AGE (In years last birthday)
73 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Crane Oper. | | 10B. KIND OF BUSINESS OR INDUSTRY
Bethlehem Steel. | | 11. BIRTHPLACE (State or foreign country)
Baltimore, Md. | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. |
| 13. FATHER'S NAME
Henry C. Henschen. | | 14. MOTHER'S MAIDEN NAME
Louisa Seibel. | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
Yes. World War One. 213-07-0563 | |
| 16. SOCIAL SECURITY NO.
#213-07-9212 | | 17. INFORMANT
Emma C. Henschen | | ADDRESS
2710 Manhattan Ave. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) Carcinoma of the colon
(B) DUE TO
(C) | | INTERVAL BETWEEN ONSET AND DEATH
May 10, 1966 | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
May 10, 1966 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
Same | | 20A. AUTOPSY? (Yes or No)
NO | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from April 10, 1966 to May 7, 1967, that (I) (we) last saw the deceased alive on May 5, 1967, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Abraham B. Hurwitz | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
May 7, 1967 | |
| 23C. PHYSICIAN'S NAME (Type)
ABRAHAM B. HURWITZ | | 23D. ADDRESS
7501 LIBERTY ROAD BALTIMORE MD. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
5-10-67 | | 24C. NAME OF CEMETERY or CREMATORY
Baltimore National Cem. | |
| 24D. LOCATION
Baltimore, Md. | | 25A. DATE REC'D BY HEALTH DEPT.
MAY 8 1967 | | | |
| 25B. NAME OF REGISTRAR
Robert E. Johnson | | 25C. FUNERAL DIRECTOR
Leonard J. Ruck, inc. 5305 Harford Rd. | | | |

BIRTH NO. 67 4478 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 4478

M.E. CASE NO.

| | | | | | | | |
|---|---------|--|------------------|---|---|--|--|
| 1. NAME OF DECEASED
(Type or Print) | | | | 2. DATE AND HOUR PRONOUNCED DEAD | | | |
| PHILLIP <u>Wayne</u> HITE, Jr. | | | | May 5, 1967 4:10 P M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | A. STATE B. COUNTY | | | |
| 44 Union Memorial Hospital | | | | Maryland | | | |
| | | | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) | | | |
| | | | | Baltimore 27-02 | | | |
| | | | | D. STREET ADDRESS (If rural, give location) | | | |
| | | | | 2709 Woodsdale Avenue | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years
last birthday) | If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min. | | |
| Male | White | single | February 1, 1967 | 3 | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| None | | | | Maryland | | USA | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| Philip Wayne Hite, Sr. | | | | Judith Ann Schwarz | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| | | | | Philip Wayne Hite, Sr. | | same | |
| 18. CAUSE OF DEATH | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | (A) DUE TO | | | |
| INTERSTITIAL PNEUMONITIS (SDII) | | | | | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | | | (B) DUE TO | | | |
| | | | | (C) DUE TO | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 2 | | | | Yes | | Yes | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| (Month) (Day) (Year) (Hour) | | WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) | | | | DATE SIGNED | | | |
| Charles S. Petty | | | | 5/6/67 | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) | | 23B. DATE | | 23C. NAME OF CEMETERY or CREMATORY | | 23D. LOCATION (City, town, or county) (State) | |
| burial | | 5-8-67 | | Holy Redeemer Cemetery | | Baltimore, Md. | |
| 24A. DATE REC'D BY HEALTH DEPT. | | 24B. NAME OF REGISTRAR | | 24C. FUNERAL DIRECTOR | | ADDRESS | |
| MAY 8 1967 | | Robert E. Taylor, M.D. | | Leonard J. Ruck Inc | | Baltimore, Md. | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 4479 | |
|---|---------|--|--------------------------|---|--------------------------------|
| CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. 67 4479 | | | | | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| KESTERSON, THOMAS ELLIS | | MAY 6, 1967 10 A. M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| ST. AGNES HOSPITAL | | MARYLAND 21202 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
40 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| WILKENS & CATON AVES.
BALTO., MD. 21229 | | BALTIMORE | | | |
| | | D. STREET ADDRESS (If rural, give location) | | | |
| | | 1200 VALLEY ST. - LITTLE SISTERS OF POOR | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years
last birthday) | 10. Under 1 Yr.
Months Days |
| MALE | WHITE | WIDOWED | 06-13-87 | 79 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| ACCOUNTANT | | ACCOUNTING | | MARYLAND | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| THOMAS F. Kesterson DEC'D | | | MARY E. (ADAMS) DEC'D | | |
| 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| NO | | 218051382 | | ST. AGNES RECORDS - BALTO., MD. 21229 | |
| 18. 154X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH
(A) CARCINOMA OF THE RECTUM,
DUE TO
WITH METASTASIS TO LYMPH NODES.
(B) _____
DUE TO
(C) _____ | |
| | | | | INTERVAL BETWEEN ONSET AND DEATH
APPROX. 4 Wks | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 5/2/67 | | RECTUM - CARCINOMA OF THE - | | NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from APRIL 22, 19 67 to MAY 6, 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on MAY 6, 19 67 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> view the body after death. | | | | | |
| 23A. SIGNATURE Thamnoon Penroach M.D. | | | | 23B. DATE SIGNED 5/6/67 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| THAMNOON PENROACH | | | | ST. AGNES' HOSP., BALTO., MD. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | |
| Burial | | 5/9/67 | | New Cathedral Cem. | |
| | | | | 24D. LOCATION (City, town, or county) (State) | |
| | | | | Balto., Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| MAY 8 1967 | | Robert E. Fisher, M.D. | | Leonard J. Ruck Inc. Balto. Md. | |

RECEIVED, TOWN OF
ST. JAMES

ALL INFORMATION
CONTAINED HEREIN IS UNCLASSIFIED

DATE 11-11-2011 BY SP-10

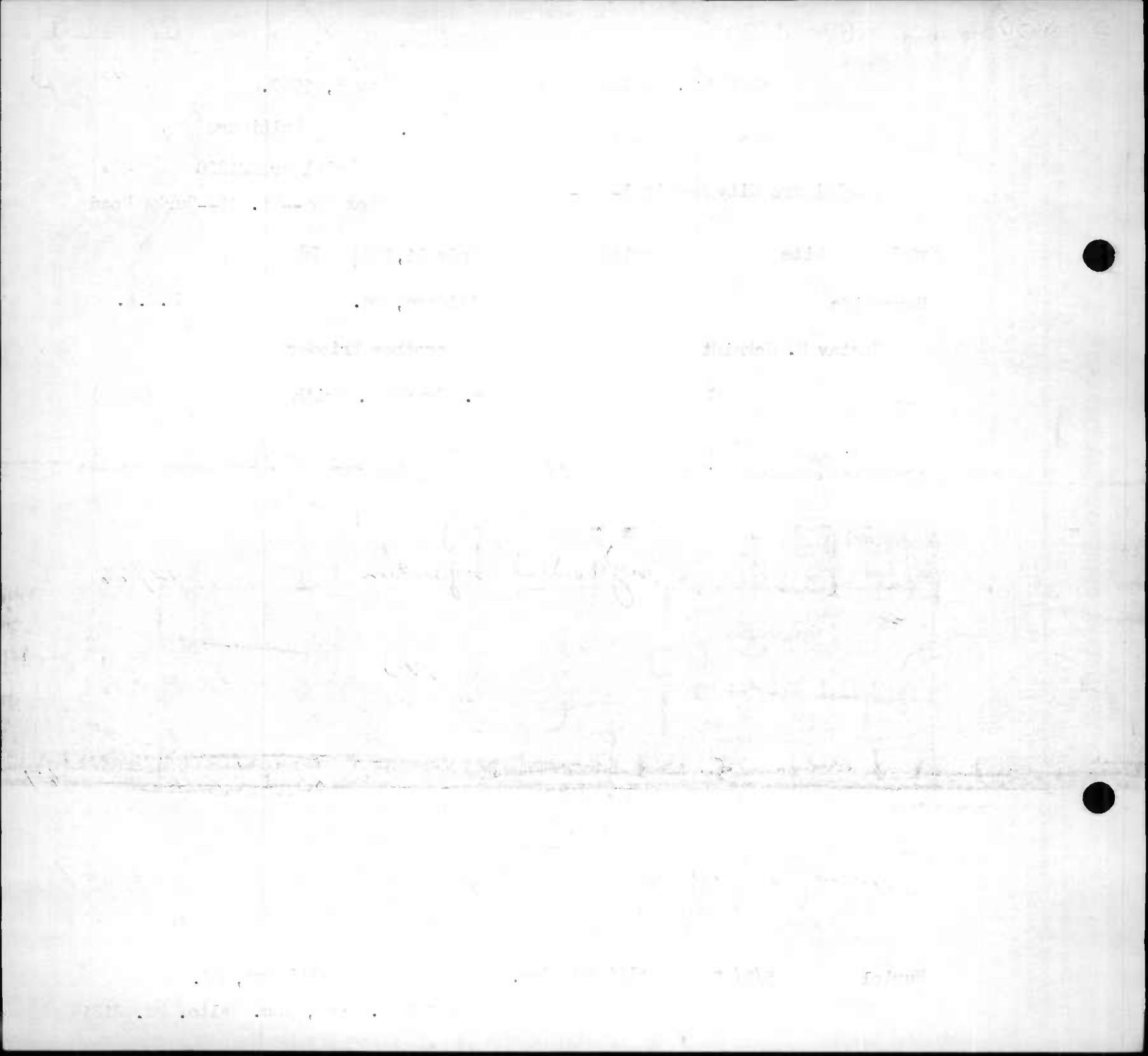
DATE 11-11-2011 BY SP-10
ACCOUNTING
TOWN OF ST. JAMES

ST. JAMES TOWN OF ST. JAMES

ST. JAMES TOWN OF ST. JAMES

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

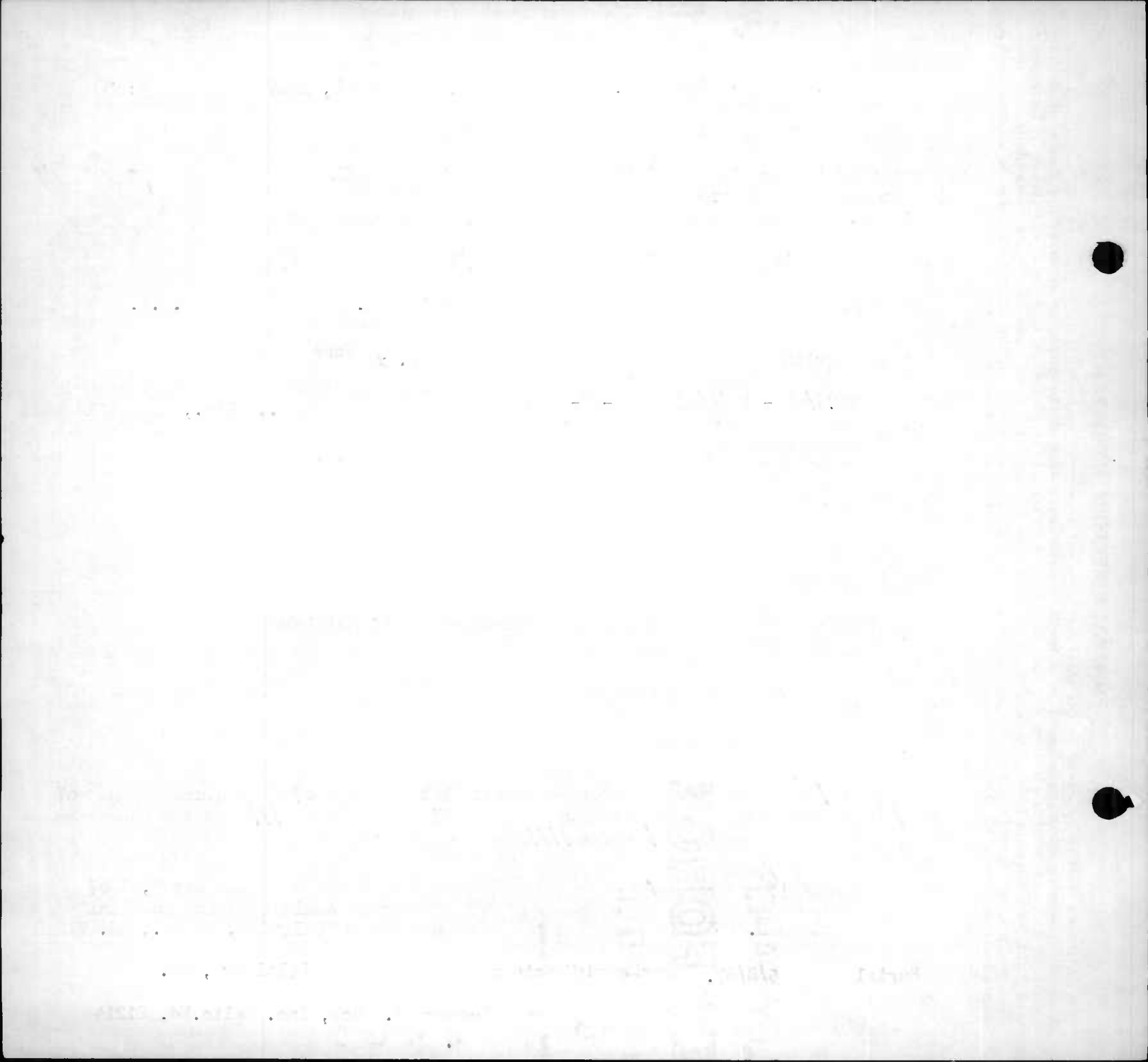
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 4480 | |
|---|----------------------|--|--|--|---|
| BIRTH NO. 67 4480 | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) ELSIE K. SMITH | |
| 2. DATE AND HOUR OF DEATH May 5, 1967. | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | |
| 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | 5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | |
| A. STATE Md. | | B. COUNTY Baltimore Co | | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | D. STREET ADDRESS (If rural, give location) | | | |
| Baltimore 21220 | | Box 475--Rt. 15--Burke Road | | | |
| 6. SEX Female | 7. RACE White | 8. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | 9. DATE OF BIRTH July 31, 1888 | 10. AGE (In years lost birthday) 78 | 11. If Under 1 Yr. Months; Days; If Under 24 Hrs. Hours; Min. |
| 12A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 12B. KIND OF BUSINESS OR INDUSTRY | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Gustav H. Schmidt | | | 14. MOTHER'S MAIDEN NAME Dorothes Krieder | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Mr. Thomas E. Smith | |
| 18. 420.11 | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | Acute Myocardial Infarction | | 2 hr | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | DUE TO | | | |
| ANTECEDENT CAUSES | | Coronary artery sclerosis | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | DUE TO | | | |
| myocardial infarction | | | | 12/66 | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1955 to 5/5 19 67 , that (I) (we) last saw the deceased alive on 3/27 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Francis J. Borges | | | | 23B. DATE SIGNED 5/6/67 | |
| 23C. PHYSICIAN'S NAME (Type) FRANCIS J. BORGES | | | | 23D. ADDRESS UNIVERSITY Hospital, Md | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 5/9/67 | | 24C. NAME OF CEMETERY OR CREMATORY Baltimore Cem. | |
| 24D. LOCATION (City, town, or county) Baltimore, Md. | | 25A. DATE REC'D BY HEALTH DEPT. MAY 8 1967 | | | |
| 25B. NAME OF REGISTRAR Robert E. Talley, M.D. | | 25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214 | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>67 4481</u> | |
|---|-------------------------|---|------------------------------------|--|---|
| BIRTH NO. <u>67 4481</u> | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | | | 2. DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED
(Type or Print) <u>BRITT, FRANKLIN CLAY SR.</u> | | | | <u>May 4, 1967</u> <u>3:40</u> P M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<u>Veterans Administration Hospital</u>
<u>3900 Loch Raven Boulevard</u>
<u>Baltimore, Maryland 21218</u> | | | | A. STATE
<u>Maryland</u> | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>Baltimore 21206</u> | |
| | | | | D. STREET ADDRESS (If rural, give location)
<u>3730 Evergreen Avenue</u> | |
| 5. SEX
<u>Male</u> | 6. RACE
<u>White</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
<u>Married</u> | 8. DATE OF BIRTH
<u>7/19/09</u> | 9. AGE (In years last birthday)
<u>57</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Salesman</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>unknown</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Paradise Mo.</u> | |
| 13. FATHER'S NAME
<u>Thomas W Britt</u> | | | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>Yes 2/25/42 - 10/5/45</u> | | | | 17. INFORMANT ADDRESS
<u>Veterans Administration Hospital Records</u>
<u>3900 Loch Raven Blvd., Balto., Md 21218</u> | |
| 16. SOCIAL SECURITY NO.
<u>345-05-9391</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Effie D. Wade</u> | |
| 18. <u>730.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
<u>Bacterial endocarditis</u> | | | | CAUSE OF DEATH
(A) <u>Bacterial endocarditis</u>
DUE TO | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
<u>Osteomyelitis</u> | | | | (B) <u>Osteomyelitis</u>
DUE TO | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
<u>Pulmonary emboli multiple</u> | | | | (C) _____ | |
| 19A. DATE OF OPERATION
<u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<u>Yes</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)
<u>Yes</u> | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>March 31st</u> 19 <u>67</u> to <u>May 4th</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>May 4th</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>David N. Marine</u> | | | | 23B. DATE SIGNED
<u>May 5, 1967</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>DAVID N. MARINE</u> | | | | 23D. ADDRESS
<u>Veterans Administration Hospital</u>
<u>3900 Loch Raven Boulevard, Balto., Md. 21218</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>5/8/67.</u> | | 24C. NAME of CEMETERY or CREMATORY
<u>Parkwood Cemetery</u> | |
| 24D. LOCATION
<u>Baltimore, Md.</u> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>MAY 8 1967</u> | | 25B. NAME OF REGISTRAR
<u>Robert E. Faby...</u> | | 25C. FUNERAL DIRECTOR
<u>Leonard J. Ruck, Inc. Balto. Md. 21214</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|--|-------------------------|---|-------------------------------------|---|----------------------------|--|-----------------------------|
| B-6010 | | 67 4482 | | BALTIMORE CITY HEALTH DEPARTMENT | | 67 4482 | |
| BIRTH NO. | | 67 4482 | | CERTIFICATE OF DEATH | | Registered No. | |
| 1. NAME OF DECEASED
(Type or Print) BIER LENORA KATHERINE | | | | 2. DATE AND HOUR OF DEATH
5TH MAR 1967 230 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
UNION MEMORIAL HOSPITAL | | (If not in hospital or institution, give street address or location) | | A. STATE
MARYLAND | | B. COUNTY | |
| C. CITY OR TOWN
BALTIMORE | | (If outside city limits, write RURAL and give township) | | D. STREET ADDRESS
1656 E BELVEDERE AVE | | | |
| 5. SEX
FEMALE | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED
WIDOWED | 8. DATE OF BIRTH
02-23-96 | 9. AGE (In years last birthday)
71 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
AMERICAN | |
| 13. FATHER'S NAME
GEORGE VAN HORN | | | | 14. MOTHER'S MAIDEN NAME
Lenora K. Parr | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
216-32-7650D | | 17. INFORMANT ADDRESS
Mrs. Bernard E. Eberwein, 308 Valley Ct. Rd. Latherville, Md. | | | |
| 18. 420.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
MYOCARDIAL INFARCTION | | | | INTERVAL BETWEEN ONSET AND DEATH
10 HOURS | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
ARTERIOSCLEROTIC CARDIOVASC DISEASE | | | | 5 YEARS? | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 5-4-67 to 5-5-67 , that (I) (we) last saw the deceased alive on 5-5-67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
Fridtjofur Bjornsson | | | | 23B. DATE SIGNED
5-5-67 | | 23C. PHYSICIAN'S NAME (Type)
FRIDTJOFUR BJORNSSON | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
5/8/67. | | 24C. NAME OF CEMETERY OR CREMATORY
Baltimore Cemetery | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 8 1967 | | 25B. NAME OF REGISTRAR
Leonard J. Ruck, Inc. | | 25C. FUNERAL DIRECTOR
Leonard J. Ruck, Inc. Balto. Md. 21214 | | ADDRESS | |

WHICH MEXICAN-AMERICAN
 FEMALE WHITE
 MARYLAND
 GEORGE VAN HORN
 AMERICAN

CARDIAC DISEASE
 ARTERIO-SCLEROTIC

NO

FRITZ OF THE LARSEN
 2-2-21
 2-2-21
 2-2-21

1
K-621

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. **67 4483** MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. **67 4483**

M.E. CASE NO.

| | | | | | | | |
|--|-------------------------|---|--|--|--|--|--|
| 1. NAME OF DECEASED
(Type or Print)
JOHN KIRKPATRICK | | | | 2. DATE AND HOUR PRONOUNCED DEAD
May 7, 1967 12:58 A.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
2900 Overland Avenue | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE Maryland
B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 27-02
D. STREET ADDRESS (If rural, give location)
2900 Overland Avenue | | | |
| 5. SEX
Male | 6. RACE
White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
Married | | 8. DATE OF BIRTH
Oct. 20, 1895 | 9. AGE (In years last birthday)
71 | If Under 1 Yr. If Under 24 Hrs.
Months, Days, Hours, Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if dead)
Steamship Co. (Ret.) | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
New Jersey. | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | 13. FATHER'S NAME
John Kirkpatrick. | | | |
| 14. MOTHER'S MAIDEN NAME
Elizabeth Ann Eberhardt | | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) (If yes, give year or dates of service)
World War One | | | |
| 16. SOCIAL SECURITY NO.
125-12-4765 | | | | 17. INFORMANT ADDRESS
Mayl. Kirkpatrick, 2900 Overland Ave. | | | |
| 18. 420.0 I CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)
Arteriosclerotic Heart Disease.
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(A).....
(B).....
(C).....
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>
CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ACTUAL SIGNATURE Charles S. Petty M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
EXAMINER'S NAME (Type) Charles S. Petty ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>
DATE SIGNED 5/7/67 | | | | | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify)
Burial. | | 23B. DATE
5/10/67 | | 23C. NAME OF CEMETERY or CREMATORY
Baltimore National Cem. | | 23D. LOCATION (City, town, or county) (State)
Baltimore, Md. | |
| 24A. DATE REC'D BY HEALTH DEPT.
MAY 8 1967 | | 24B. NAME OF REGISTRAR
Robert E. Taylor | | 24C. FUNERAL DIRECTOR
Leonard J. Ruck, inc. | | 24D. ADDRESS
5305 Harford Rd. | |

19670004491

✓

WILLIAM FORGE

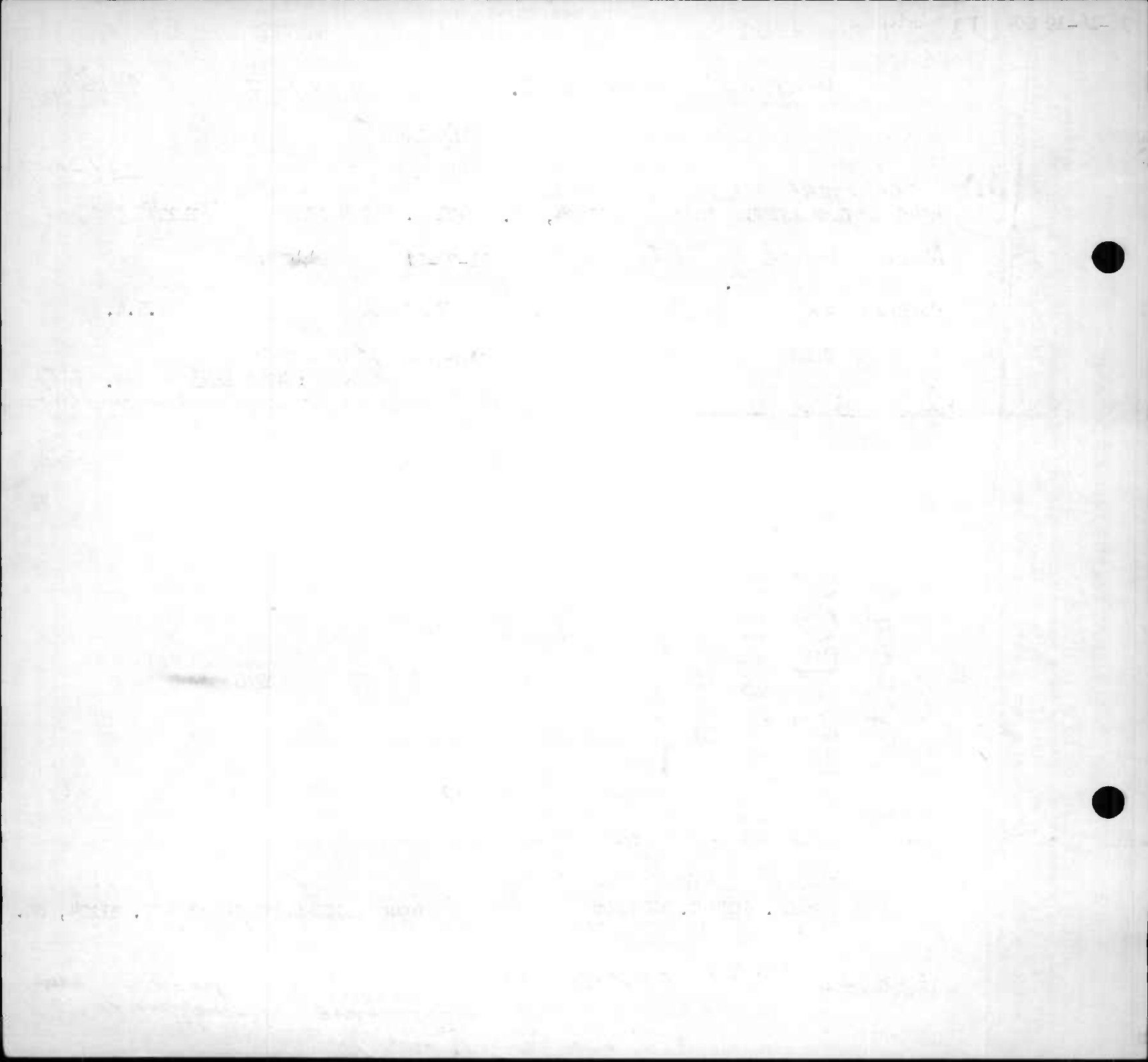
WILLIAM FORGE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|--|--|--|--|
| 1. NAME OF DECEASED
(Type or Print) HARTLEY LONNIE L. | | 2. DATE AND HOUR OF DEATH
5/3/67 9.15 p.m. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
31 BALTIMORE City Hospital
4940 EASTERN AVENUE BALTIMORE 21224, MD. | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE MARYLAND
B. COUNTY BALTIMORE
C. CITY OR TOWN (If outside city limits, write RURAL and give township) 26-07
D. STREET ADDRESS (If rural, give location) 421 S. MACON STREET #21224 | |
| 5. SEX
MALE | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
MARRIED | 8. DATE OF BIRTH
11-24-21 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
CARPENTER | | 10B. KIND OF BUSINESS OR INDUSTRY | 9. AGE (In years last birthday) 45 |
| 13. FATHER'S NAME
JESSE | | 11. BIRTHPLACE (State or foreign country)
VIRGINIA | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
YES W.W. II | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 16. SOCIAL SECURITY NO. | | 14. MOTHER'S MAIDEN NAME
MARY KAUNTZ | |
| 17. INFORMANT
DR. J. WHELTON | | ADDRESS RECORDS: 4940 Eastern Ave. Hosp. BALTIMORE City | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
493X I
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)
Pneumonia. | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
CHRONIC OBSTRUCTIVE PULMONARY DISEASE. | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
LUNG ABSCESS. | | | |
| 19A. DATE OF OPERATION
2 | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No)
YES | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
YES |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (if this hospital) attended the deceased from 4-20-67 1967 to 5/3 1967, that (I) (we) last saw the deceased alive on 5/3 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE
John C. Whelton | | 23B. DATE SIGNED
5/3/67 | |
| 23C. PHYSICIAN'S NAME (Type)
DR. JOHN C. WHELTON | | 23D. ADDRESS
4940 EASTERN AVENUE BALTO. 21224, MD. BALTIMORE City Hospital | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
REMOVAL | 24B. DATE
5/5/67 | 24C. NAME OF CEMETERY OR CREMATORY
OXFORD CEM. | 24D. LOCATION (City, town, or county) (State)
LEXINGTON VA. |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 8 1967 | 25B. NAME OF REGISTRAR
Robert E. Fairbank | 25C. FUNERAL DIRECTOR
J.G. CONNELLY SONS 300 MACE VARIER + POLE LEXINGTON VA | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 67 4485 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | Registered No. 67 4485 | |
|---|------------------|--|--|--|---|--|--|--|--|
| 1. NAME OF DECEASED
(Type or Print) EDNA BISHOP (BISHOFF) | | | | 2. DATE AND HOUR OF DEATH
5/4/67 A. M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
35 Church Home & Hospital | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE MD B. COUNTY BALTO Co
C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 53-00
D. STREET ADDRESS (If rural, give location) 7607 Wilhelm Ave. #06 | | | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) M | | 8. DATE OF BIRTH
8-24-18 | 9. AGE (In years last birthday) 48 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
WAITRESS | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
W. VA. | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
ALBERT CHIDESTER | | | | 14. MOTHER'S MAIDEN NAME
MARY FIKE | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
— | | | | 16. SOCIAL SECURITY NO.
214-20-4758 | | 17. INFORMANT
WADE BISHOFF | | ADDRESS
ABOVE | |
| 18. 1750 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
OVARIAN CA
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
GENERALIZED METASTASIS | | | | CAUSE OF DEATH
(A) DUE TO
(B) DUE TO
(C) INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
— | | | | | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
NONE ON THIS admission | | 20A. AUTOPSY? (Yes or No)
NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nearly medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
— | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR?
— | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 3-14 1967 to 5-4 1967 , that (I) (we) last saw the deceased alive on 5-4 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
Asclembro | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
5-4-67 | | | |
| 23C. PHYSICIAN'S NAME (Type)
Dr. Paul Herold | | | | M.D. 23D. ADDRESS
CH & H | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
5/8/67 | | 24C. NAME OF CEMETERY or CREMATORY
GARDENS OF FAITH | | 24D. LOCATION (City, town, or county) (State)
BALTO. MD | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 8 1967 | | 25B. NAME OF REGISTRAR
Robert E. Fairbank | | 25C. FUNERAL DIRECTOR
J. G. CONNELLEY SONS | | ADDRESS
300 MACE | | | |

ORIGINAL

WALBURY

on that hand
admission

CH 44

2-4 3-14 2-4
1-4

General interest
Crown CA

Mary Fite
W. W.

Albert Chidester
W. W.

Church Home & Hospital
W. W.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>67 4486</u> | |
|--|-------------------------|---|--|--|---|
| BIRTH NO. <u>67 4486</u> | | | | | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED
(Type or Print) <u>Roth, Leroy</u> LeRoy J. Roth | | | 2. DATE AND HOUR OF DEATH
<u>5/5/67</u> <u>3:20 A.M.</u> | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<u>33</u> The Johns Hopkins Hospital | | | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)
A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore Co.</u>
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>Baltimore - Dundalk</u> <u>53-00</u>
D. STREET ADDRESS (If rural, give location)
<u>7500 Battle Grove Circle</u> | | |
| 5. SEX
Male | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married | 8. DATE OF BIRTH
11-07-06 | 9. AGE (In years last birthday)
60 | 10. Under 1 Yr. Months: Days: If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Radio Dispatcher | | 10B. KIND OF BUSINESS OR INDUSTRY
Balto. Gas & Electric Co. | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 13. FATHER'S NAME
John J. Roth | | | 14. MOTHER'S MAIDEN NAME
Catherine Margotten | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
212-05-4289 | | 17. INFORMANT
(Name) <u>Dundalk, Md. 21222</u>
Mrs. Harriet Roth, 7500 Battle Grove Circle, | |
| 18. <u>5-40-11</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
Bile peritonitis
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Perforated ulcer | | | CAUSE OF DEATH
(A) <u>Bile peritonitis</u>
DUE TO
(B) <u>Perforated ulcer</u>
DUE TO
(C) _____ | | |
| 18. <u>II</u>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Rheumatoid arthritis + aortic | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| 19A. DATE OF OPERATION
<u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | |
| 20A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) <u>this hospital</u> attended the deceased from <u>4-13</u> 19 <u>67</u> to <u>5-5</u> 19 <u>67</u> , that (I) <u>we</u> last saw the deceased alive on <u>5/5</u> 19 <u>67</u> and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>we</u> (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>P. J. Rosen</u> | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
05-05-67 |
| 23C. PHYSICIAN'S NAME (Type)
Peter J. Rosen | | | 23D. ADDRESS
M.D. The Johns Hopkins Hospital | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
5/8/67 | | 24C. NAME of CEMETERY or CREMATORY
Ebenezer Cemetery | |
| 24D. LOCATION
Chase, Maryland | | 24E. FUNERAL DIRECTOR
John J. Duda, 7922 Wise Ave. Dundalk, Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 8 1967 | | 25B. NAME OF REGISTRAR
Robert E. Taylor | | 25C. FUNERAL DIRECTOR
John J. Duda, 7922 Wise Ave. Dundalk, Md. | |

Roll, 2nd

8/2/11

Performs it where
File printed

Resistant to attack + decay

2/2
00

Pharm

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ERNEST F. KANE

2. DATE AND HOUR PRONOUNCED DEAD

May 4, 1967

8:30 A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)Police Boat Gaither
Harbor, Foot of Bond Street4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

6116 Bessemer Avenue

21224

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

June 23-1923

9. AGE (In years
last birthday)

43

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Self-employed

10B. KIND OF BUSINESS OR INDUSTRY

Tavern

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John J. Kroleczyk-Kane

14. MOTHER'S MAIDEN NAME

Mary Rozanski

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes,

Army WWII

16. SOCIAL
SECURITY NO.

219-12-8195

17. INFORMANT

ADDRESS

Wife, Sonia Kane, #4, a, b, c, d.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Gunshot Wounds of Abdomen.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Unknown

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Unknown

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
5 4 '67 A

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Shot in abdomen.

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Petty

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

5/4/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

May-20-1967

23C. NAME of CEMETERY or CREMATORY

St. Stanislaus

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland 21224

24A. DATE REC'D BY HEALTH DEPT.

MAY 8 1967

24B. NAME OF REGISTRAR

Robert E. Farkas

24C. FUNERAL DIRECTOR

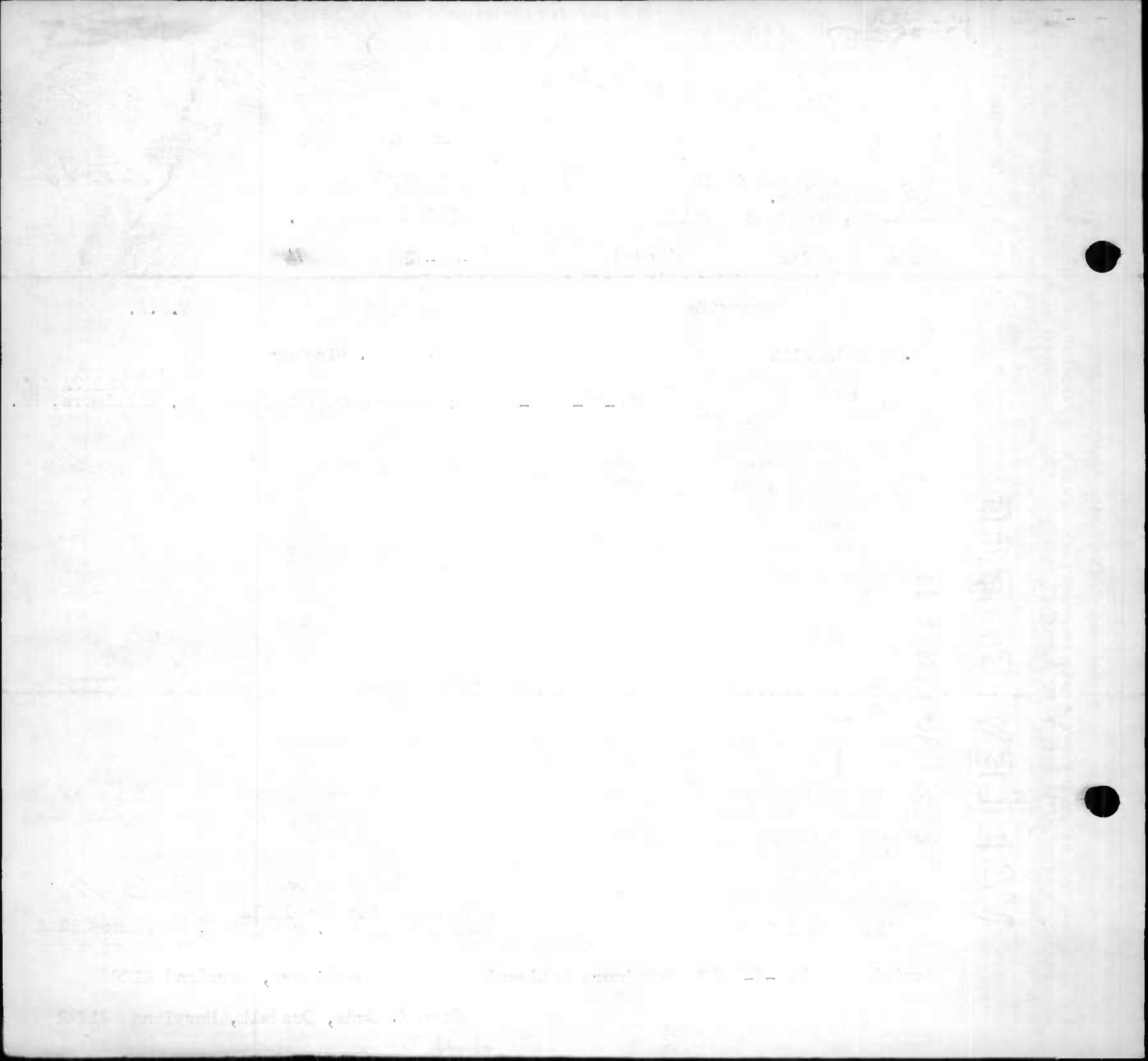
John J. Duda, Baltimore, Maryland 21224

ADDRESS

WILLIAM PORTER

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|--|--|--|--|------------------------------|
| R-560 67 4488 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 4488 | |
| BIRTH NO. | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) | |
| 67 4488 | | | | Bessie Rymer | |
| 2. DATE AND HOUR OF DEATH | | 5/15/67 2:00 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE B. COUNTY | | | |
| Baltimore City Hospitals
4940 Eastern Ave.
Baltimore, Maryland #21224 | | Maryland
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
4940 Eastern Ave. | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years lost birth) | 10. Under 1 Yr. Months Days |
| Female | White | Widowed | 10-16-92 | 74 | 11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Housewife | | | | Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? | | U.S.A. | | | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | | |
| D. Lincoln Wilt | | Fanny L. Blocher | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| No | | 216-16-2492-A | | BCH: Records 4940 Eastern Ave. Baltimore, Md. #21224 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| Pneumonia | | (A) DUE TO | | 3 wks | |
| ANTECEDENT CAUSES | | (B) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) DUE TO | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | Hypertension | | rev. yes | |
| 19A. DATE OF OPERATION | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 2 | | YES | YES | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (1) (this hospital) attended the deceased from 5/11/67 to 5/15/67, that (1) (we) last saw the deceased alive on 5/15/67 and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| Mary Ann Sullivan M.D. | | | | 5/15/67 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| Mary Ann Sullivan | | Baltimore City Hospitals
4940 Eastern Ave. Baltimore, Maryland #21224 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY or CREMATORY | 24D. LOCATION (City, town, or county) (State) | | |
| Burial | May-9-1967 | Baltimore National | Baltimore, Maryland 21228 | | |
| 25A. DATE REC'D BY HEALTH DEPT. | 25B. NAME OF REGISTRAR | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| MAY 8 1967 | Robert E. Egan | John J. Duda, Dundalk, Maryland | | 21222 | |



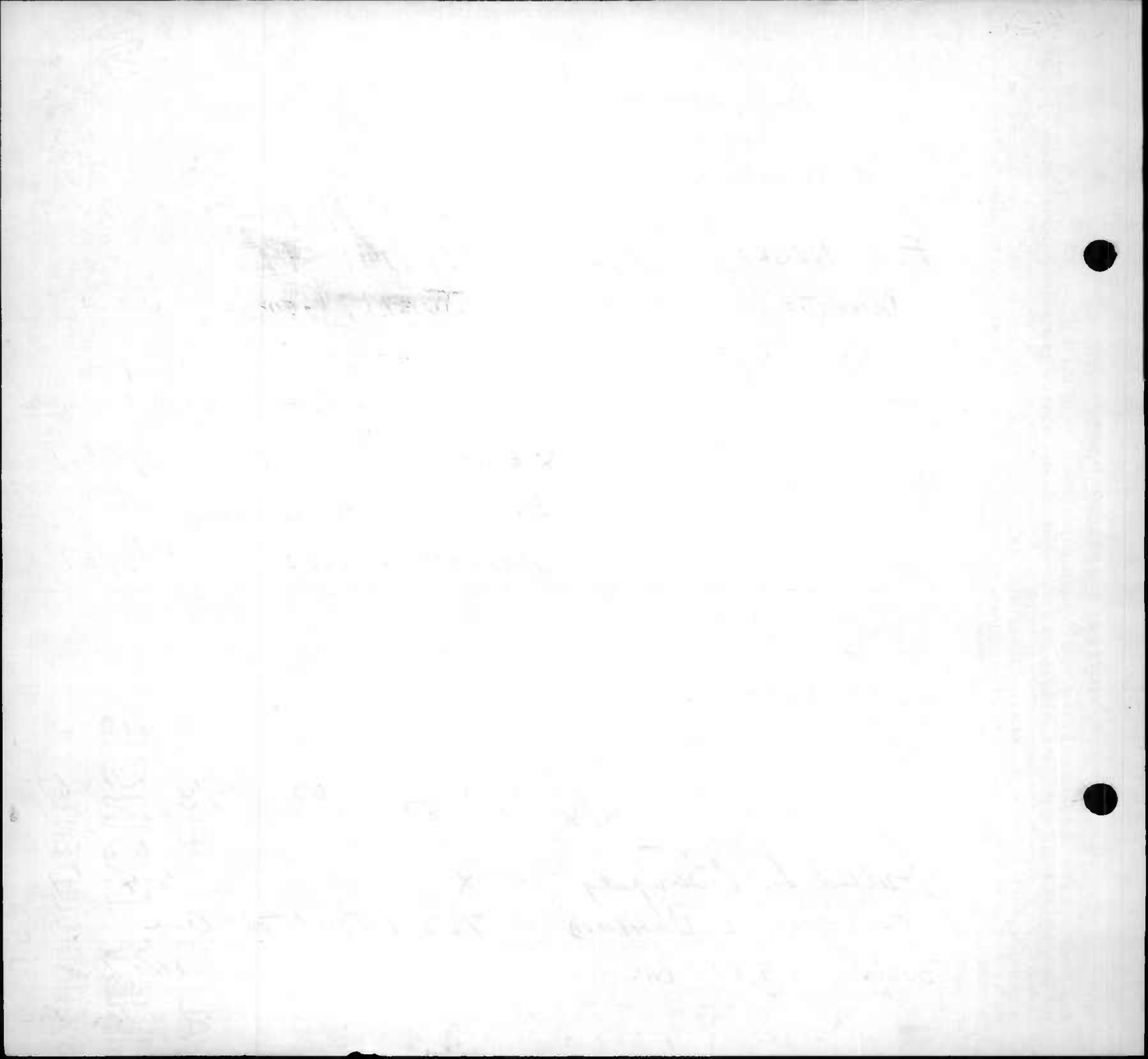
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | | |
|---|----------------------|---|---|---|--|--|--|--|---|---|--|--|
| CERTIFICATE OF DEATH | | | | | Registered No. <u>67 4489</u> | | | | | | | |
| BIRTH NO. <u>67 4489</u> | | M.E. CASE NO. | | | 1. NAME OF DECEASED
(Type or Print) <u>Ruby L. Lyles</u> | | | | | 2. DATE AND HOUR OF DEATH
<u>5/4/67</u> <u>7 45</u> P. M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION: <u>PROVIDENT HOSPITAL</u>
(If not in hospital or institution, give street address or location) | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <u>MD</u>
B. COUNTY <u>BALTIMORE</u>
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>20-07</u>
D. STREET ADDRESS (If rural, give location) <u>250 N. HILTON STREET</u> | | | | | | | |
| 5. SEX <u>F</u> | 6. RACE <u>NEGRO</u> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) <u>MARRIED</u> | | 8. DATE OF BIRTH <u>7/4/1917</u> | 9. AGE (In lost hr. <u>49</u>) | 10. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) <u>DOMESTIC</u> | | 11. BIRTHPLACE (State or foreign country) <u>JUETT, GEORGIA</u> | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u> | | | |
| 13. FATHER'S NAME <u>NEIL ALLEN</u> | | | | 14. MOTHER'S MAIDEN NAME <u>ORA ?</u> | | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | | | | |
| 16. SOCIAL SECURITY NO. <u>212-24-7569</u> | | | | 17. INFORMANT <u>MR. JOHNNIE LYLES</u> | | | | ADDRESS <u>250 N. FULTON AVE</u> | | | | |
| 18. <u>331X I</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | CAUSE OF DEATH
(A) <u>CEREBRAL HEMORRHAGE</u>
DUE TO
(B) <u>ESSENTIAL HYPERTENSION</u>
DUE TO
(C) <u>ARTERIOSCLEROSIS</u> | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>5/2/67</u>
<u>to</u>
<u>5/4/67</u> | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>5/2/67</u> <u>1967</u> to <u>5/4/67</u> <u>1967</u> .
that (I) (we) last saw the deceased alive on <u>5/4/67</u> <u>1967</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 23A. SIGNATURE <u>GILBERT L. BANFIELD</u> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | | | | | | 23B. DATE SIGNED <u>5-4-67</u> | | | | |
| 23C. PHYSICIAN'S NAME (Type) <u>GILBERT L. BANFIELD</u> | | | | 23D. ADDRESS <u>722 N. FULTON AVE</u> | | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24B. DATE <u>5/9/67</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>BALTIMORE NATIONAL CEM.</u> | | | 24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>MAY 8 1967</u> | | | 25B. NAME OF REGISTRAR <u>R.D. E. FAY</u> | | | 25C. FUNERAL DIRECTOR <u>HERBERT E. NUTTER</u> ADDRESS <u>3035 W. NORTH AVE</u> | | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|---------------------|--|---|--|---|
| 67 4490 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 4490 | |
| BIRTH NO. | | CERTIFICATE OF DEATH | | 2. DATE AND HOUR OF DEATH | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) <u>Melvin Lindsay</u> | | 4/23-67 12 ³⁰ A.M. | |
| 1. NAME OF DECEASED
(Type or Print) | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | A. STATE
B. COUNTY | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location)
<u>38 University Hospital</u> | | C. CITY OR TOWN
(If outside city limits, write RURAL and give township)
<u>Baltimore 19-03</u> | | D. STREET ADDRESS
(If rural, give location)
<u>1528 Hollins St</u> | |
| 5. SEX
<u>M</u> | 6. RACE
<u>W</u> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<u>S</u> | 8. DATE OF BIRTH
<u>9/19/24</u> | 9. AGE (In years last birthday)
<u>42</u> | If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country)
<u>USA</u> | | 12. CITIZEN OF WHAT COUNTRY
<u>USA</u> |
| 13. FATHER'S NAME
<u>Herman Robinson Lindsey</u> | | | 14. MOTHER'S MAIDEN NAME
<u>Edith Robertson</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS | | |
| 18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
<u>Broadbogenic CA</u>
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
<u>CNS metastasis</u> | | CAUSE OF DEATH
(A) DUE TO
(B) DUE TO
(C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH
<u>6 mos</u> | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<u>YES</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>2/25</u> 19 <u>67</u> to <u>4/23</u> 19 <u>67</u> .
that (I) (we) last saw the deceased alive on <u>4/22</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>Sandra Z. Salan</u> | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
<u>4/23/67</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>Sandra Z. Salan</u> | | 23D. ADDRESS
<u>UNIV. HOSPITAL MARYLAND</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE
<u>5-2-67</u> | | 24C. NAME OF CEMETERY or CREMATORY | |
| 24D. LOCATION (City, town, or county) | | 24E. STATE (State) | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>MAY 9 1967</u> | | 25B. NAME OF REGISTRAR
<u>Robert E. Fairman</u> | | 25C. FUNERAL DIRECTOR ADDRESS
<u>HOSPITAL DISPOSAL</u> | |

11/11/11

12/11/11

2

W

Heavenly Robinson (Cindy) 11/11/11

USA

5 C in 2 metastases

11/11/11

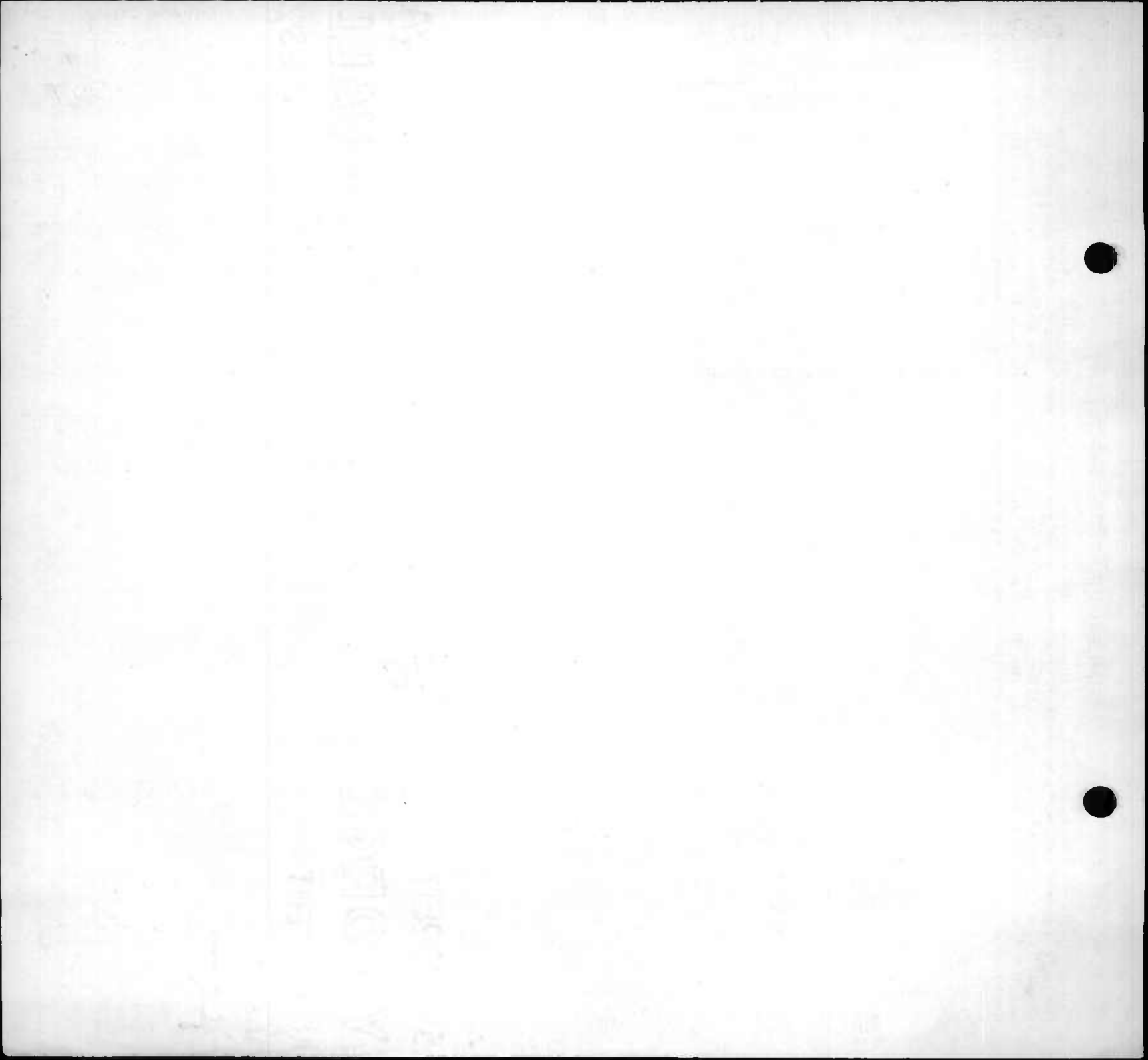
Heavenly Robinson (Cindy) 11/11/11

USA

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|--------------|---|-----------------------------|--|---|
| BIRTH NO. 67 4491 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 4491 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) MAJOR SYDNOR | | 2. DATE AND HOUR OF DEATH
4/26/67 5:30 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE MARYLAND
B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
38 University | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE 22-02 | | | |
| | | D. STREET ADDRESS (If rural, give location)
202 W Camden St 21201 | | | |
| 5. SEX
M | 6. RACE
N | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
2 | 8. DATE OF BIRTH
9/20/97 | 9. AGE (In years last birthday)
69 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| | | | | | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | | |
| | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| | | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
433.11 | | CAUSE OF DEATH
(A) Arteriosclerotic Cardiovasc. Dis.
(B) Generalized Arteriosclerosis
(C) Pulmonary Edema
Coccythmia
pneumonia | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 4/21/67 19 to 4/26 1967.
that (I) (we) last saw the deceased alive on 4/26/67 19. and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
E. Ann Robinson | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
4/26/67 | |
| 23C. PHYSICIAN'S NAME (Type)
EANN ROBINSON | | 23D. ADDRESS
University Hospital | | 23E. CITY, TOWN, OR COUNTY
BALTIMORE | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE
5-2-67 | | 24C. NAME OF CEMETERY OR CREMATORY
UNIVERSITY MEDICAL SCHOOL | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 9 1967 | | 25B. NAME OF REGISTRAR
E. Ann Robinson | | 25C. FUNERAL DIRECTOR
HOSPITAL DISPOSAL | |



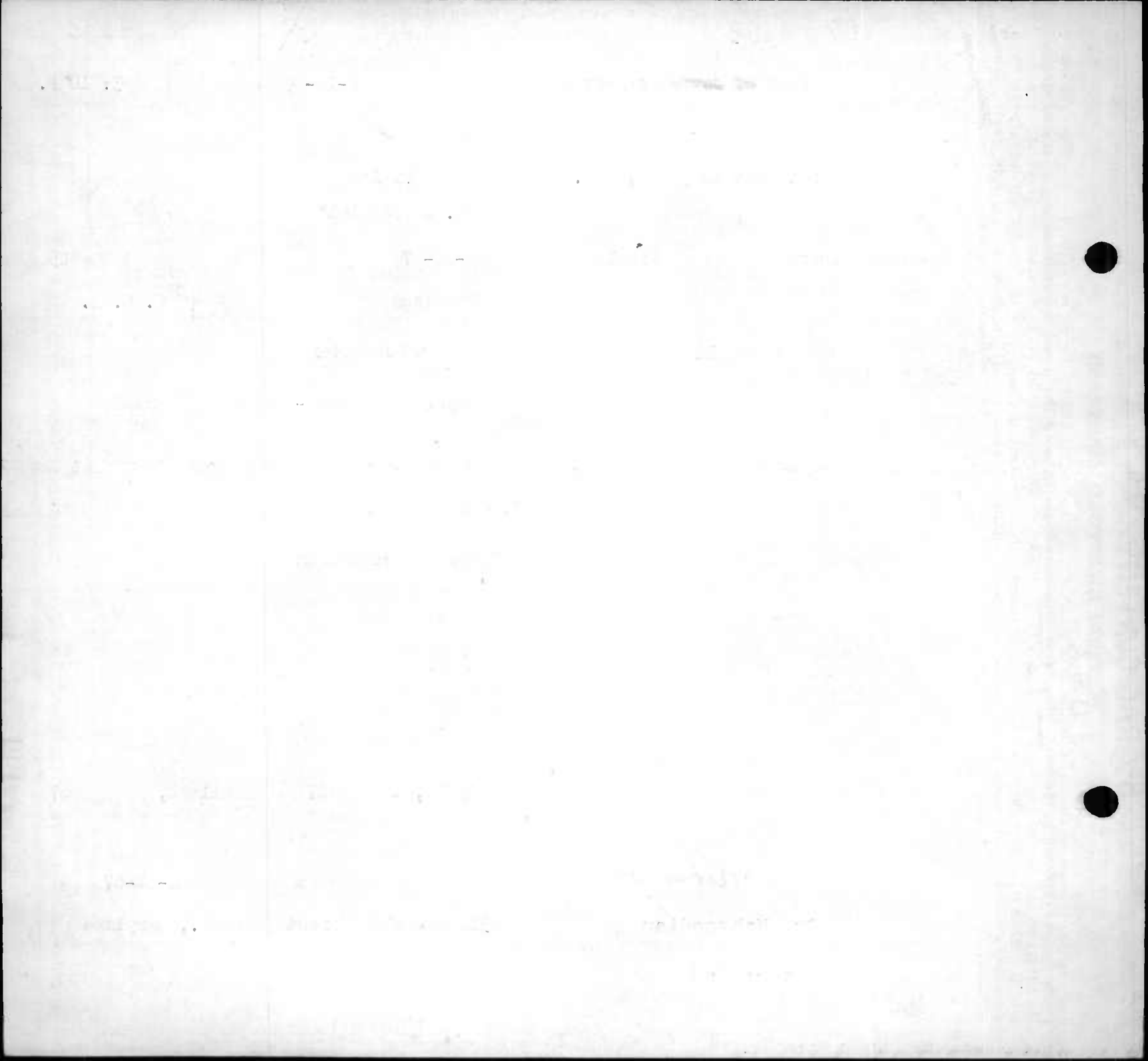
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Certificate of Death | | Registered No. 67 4492 | |
|---|---|---|--|--|-------------------------------|---|---|
| BIRTH NO. 67-07299 | | M.E. CASE NO. 4492 | | 1. NAME OF DECEASED
(Type or Print) Baby of Joyce ^{GIRL} Forrester | | 2. DATE AND HOUR OF DEATH
4-10-67 3: 10 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
39 Provident Hospital, Inc. | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY 9.9. Co.
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Glen Burnie
D. STREET ADDRESS (If rural, give location) 52-00
Rt. 2 Box 181 | | | |
| 5. SEX
Female | 6. RACE
Negro | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Single | 8. DATE OF BIRTH
4-10-67 | 9. AGE (In years last birthday) | If Under 1 Yr.
Months Days | If Under 24 Hrs.
Hours Min. | 25 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
Robert Gambrill | | | | 14. MOTHER'S MAIDEN NAME
Joyce Forrester | | | |
| 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Joyce Forrester - mother | | ADDRESS
SAME | |
| 18. 752X1
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH
(A) Hydrocranium, cause undetermined
DUE TO
Atrophy of brain
(B)
DUE TO
(C) Atelectasis neonatorum | | INTERVAL BETWEEN ONSET AND DEATH | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from April 10, 1967 to April 10, 1967 , that (I) (we) last saw the deceased alive on April 10, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
Mahmoodian | | | | | | 23B. DATE SIGNED
4-18-67 | |
| 23C. PHYSICIAN'S NAME (Type)
Dr. Mahmoodian | | | | 23D. ADDRESS
M.D. 1514 Division Street Balto., Maryland | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
4-27-67 | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State)
UNIVERSITY MEDICAL SCHOOL
MORTUARY SERVICE - BCHD | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 9 1967 | | 25B. NAME OF REGISTRAR
Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR | | ADDRESS | |



1
S-530

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 67 4493 | | | |
|---|--|--|--|---|--|--|--|
| BIRTH NO. | | | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. | | | |
| M.E. CASE NO. | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) | | | | 2. DATE AND HOUR PRONOUNCED DEAD | | | |
| LILA P. SMITH | | | | 4-15-67 | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| | | | | A. STATE
Maryland | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) | | | |
| 1313 E. BIDDLE STREET - Amb. Crew #7 | | | | Baltimore | | | |
| | | | | D. STREET ADDRESS (If rural, give location) | | | |
| | | | | 1313 E. Biddle Street | | | |
| 5. SEX | | 6. RACE | | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH | |
| Female | | Colored | | | | 9. AGE (In years last birthday)
65 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| | | | | | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give year or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| | | | | | | | |
| 18. CAUSE OF DEATH | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | Pulmonary emphysema, purulent bronchitis | | | |
| II
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | | | an bronchiectases | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 2 | | | | Yes | | Yes | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| (Month) (Day) (Year) (Hour) | | WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | |
| | | | | | | | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE
EXAMINER'S NAME (Type) | | | | DATE SIGNED | | | |
| Werner U. Spitz, M.D. | | | | 4-16-67 | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) | | 23B. DATE | | 23C. NAME OF CEMETERY or CREMATORY | | 23D. LOCATION (City, town, or county) | |
| | | 5-1-67 | | UNIVERSITY MEDICAL SCHOOL | | MORTUARY SERVICE - BCHD | |
| 24A. DATE REC'D BY HEALTH DEPT. | | 24B. NAME OF REGISTRAR | | 24C. FUNERAL DIRECTOR | | ADDRESS | |
| MAY 9 1967 | | Robert E. Farber, M.D. | | | | | |

WALFLEY FORGE

20/NOV/1951

100-200000

49-10-16 GG 1 W-123

67 4494

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

67 4494

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Edward Webster

2. DATE AND HOUR OF DEATH

4-20-67

8:00

P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)BALTIMORE CITY HOSPITALS
4940 EASTERN AVENUE
BALTIMORE 21224, MARYLAND4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

MARYLAND

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

BALTIMORE

D. STREET ADDRESS (If rural, give location)

615 E. BALTIMORE STREET

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

WIDOWED

8. DATE OF BIRTH

6-19-08

9. AGE (In years
last birthday)

58

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

JULIUS

14. MOTHER'S MAIDEN NAME

HELEN

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

RECORDS: BCH 4940 EASTERN AVENUE # 21224

18.

493X I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A)

Pneumonia

DUE TO

days

(B)

Pneumococcal infection

DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

dehydration

days

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 18 April 19 67 to 20 April 19 67,
that (I) (we) last saw the deceased alive on 20 April 19 67 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Joseph D Berman

M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

4-20-67

23C. PHYSICIAN'S
NAME (Type)

Dr. Joseph Berman

M.D.

23D. ADDRESS

Baltimore City Hospitals 4940 Eastern Ave
#2122424A. BURIAL CREMATION,
REMOVAL (Specify)

24B. DATE

5-8-67

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county)

25A. DATE REC'D BY HEALTH DEPT.

MAY 9 1967

25B. NAME OF REGISTRAR

Robert E. Farley, M.D.

25C. FUNERAL DIRECTOR

ADDRESS

UNIVERSITY MEDICAL SCHOOL
MORTUARY SERVICE - BCHD

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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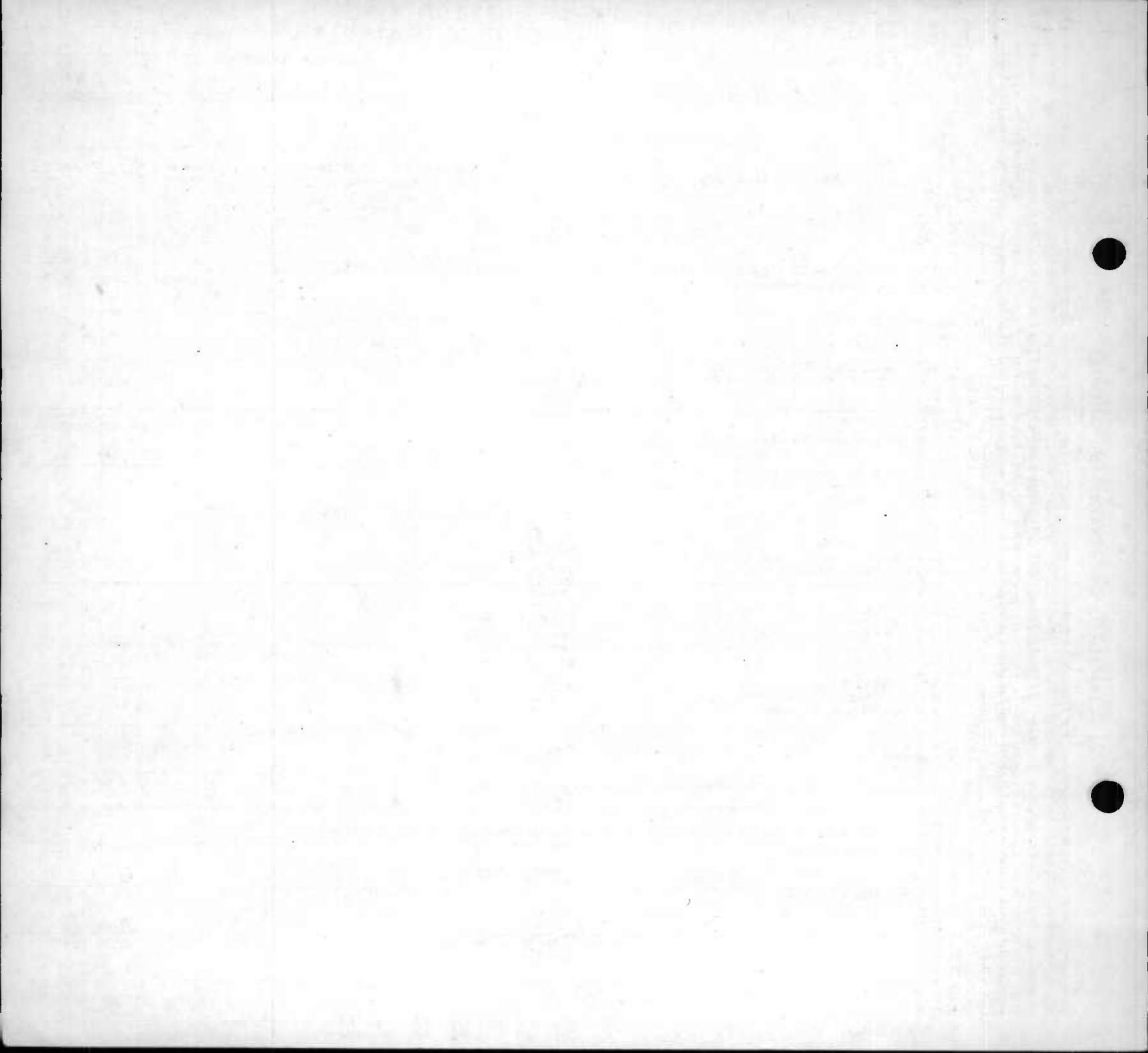
2/1

2/1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|---|--------------|---|-----------------------------|--|----------------------------|--|--|
| BIRTH NO. 67-07709 | | 4495 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 4495 | |
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) BABY GIRL CORNWELL | | | | 2. DATE AND HOUR OF DEATH
4/22/67 4:50A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE MARYLAND B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
LUTHERAN HOSPITAL OF MARYLAND | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
3106 E WALLFORD DR BALTIMORE | | | |
| | | | | D. STREET ADDRESS (If rural, give location)
3106 E WALLFORD DR #2253-00 | | | |
| 5. SEX
F | 6. RACE
W | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH
4/21/67 | 9. AGE (In years lost birthday) | If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME
ALVIN T. | | | | 14. MOTHER'S MAIDEN NAME
CHRISTAR, HENNECK | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| 18. 773.51 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
PREMATURITY
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
RESPIRATORY DISTRESS SYNDROME | | | | INTERVAL BETWEEN ONSET AND DEATH
10 hrs 30 min | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 4/21 19 67 to 4/22/67 19 67, that (I) (we) lost saw the deceased alive on 4/22 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
F. Heroma | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
4/22/67 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS
LUTHERAN HOSPITAL OF MARYLAND | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE
5-2-67 | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 9 1967 | | 25B. NAME OF REGISTRAR
R. B. E. F. Heroma | | 25C. FUNERAL DIRECTOR
MORTUARY SERVICE - BCHD | | ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|---------------|--|---|------------------------------------|--|
| BIRTH NO. 67 4496 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 4496 | |
| M.E. CASE NO. 67-08262 | | | CERTIFICATE OF DEATH | | |
| 1. NAME OF DECEASED (Type or Print) BABY GIRL EUBANKS | | | 2. DATE AND HOUR OF DEATH 5/1/67 2:50A.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSPITAL | | | A. STATE MARYLAND B. COUNTY BALTIMORE | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | | D. STREET ADDRESS (If rural, give location) 4115 THE ALAMEDA | | |
| 5. SEX FEMALE | 6. RACE NEGRO | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) - | 8. DATE OF BIRTH 4/30/67 | 9. AGE (In years last birthday) 19 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. 43 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE | | 10B. KIND OF BUSINESS OR INDUSTRY - | 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME ROBERT EUBANKS | | | 14. MOTHER'S MAIDEN NAME GLORIA PAYNE | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS | | |
| 18. 773.51 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | CAUSE OF DEATH (A) PREMATUREITY & SEVERE (B) RESPIRATORY DISTRESS. (C) | | INTERVAL BETWEEN ONSET AND DEATH 19 HRS 43 MIN. |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that (this hospital) attended the deceased from 4/30/1967 to 5/1/1967, that (we) lost saw the deceased alive on 5/1/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE K. Shaw | | | 23B. DATE SIGNED 5/1/67 | | |
| 23C. PHYSICIAN'S NAME (Type) KAILIE R.B. SHAW, | | | 23D. ADDRESS THE UNION MEMORIAL HOSPITAL | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE 5-4-67 | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) |
| 25A. DATE REC'D BY HEALTH DEPT. MAY 9 1967 | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| JOHNS HOPKINS MEDICAL SCHOOL MORTUARY SERVICE - BCHD | | | | | |

0.0

Low tide

10/10/02

10/10/02

10/10/02

10/10/02

10/10/02

10/10/02

10/10/02

10/10/02

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10/10/02

10/10/02

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

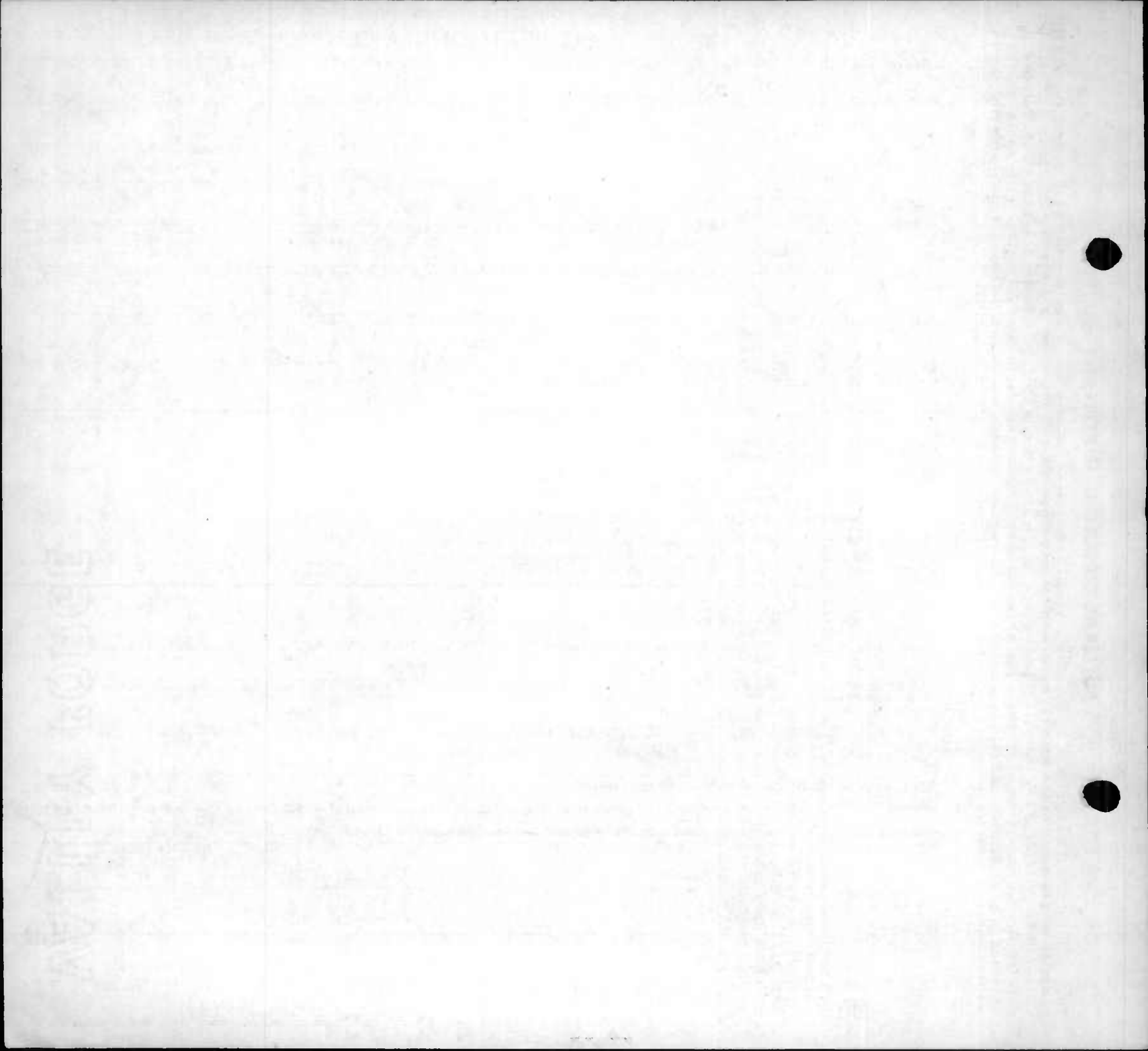
| BALTIMORE CITY HEALTH DEPARTMENT | | | | BIRTH NO. <u>67-57794487</u> | | REGISTERED NO. <u>67 4487</u> | |
|---|---------------------|---|------------------------------------|--|---------------------------------------|--|--|
| CERTIFICATE OF DEATH | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) <u>BABY BOY JONES</u> | | | | 2. DATE AND HOUR OF DEATH
<u>4-14-67</u> <u>11:45 P.M.</u> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<u>38 UNIVERSITY HOSPITAL BALTIMORE</u> | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE _____ B. COUNTY _____

C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>Baltimore 31218 Nod.</u>
D. STREET ADDRESS (If rural, give location)
<u>2622 Kinkadee</u> | | | |
| 5. SEX
<u>M</u> | 6. RACE
<u>N</u> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<u>N.V.</u> | 8. DATE OF BIRTH
<u>4-14-67</u> | 9. AGE (In years last birthday)
____ | If Under 1 Yr.
Months: Days: _____ | If Under 24 Hrs.
Hours: Min. _____ | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>BALTIMORE, MD.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>unk</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Martine Jones</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| 18. <u>75-3,11</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

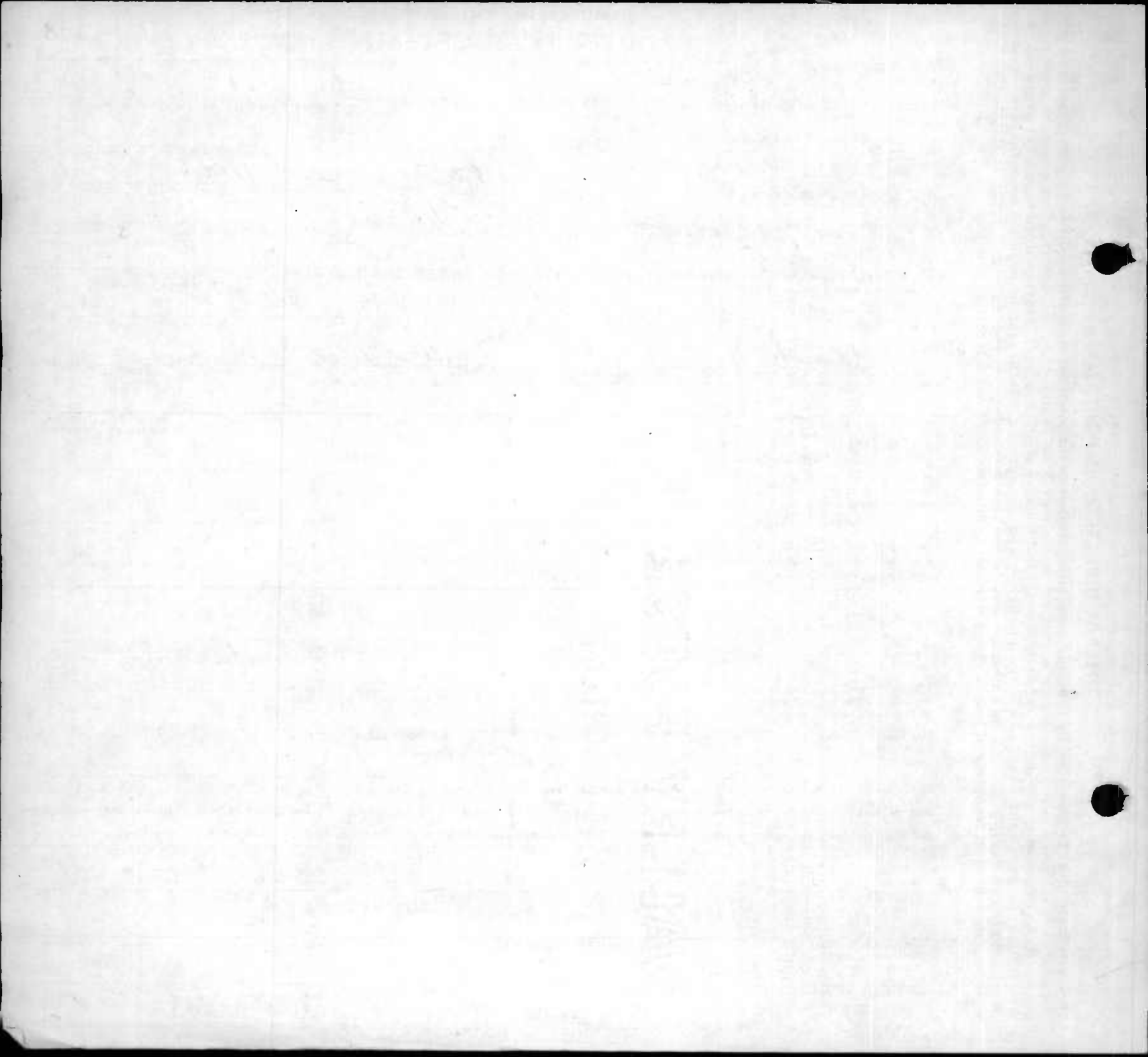
<u>II</u>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | CAUSE OF DEATH
(A) <u>Pulmonary atelectasis & cerebral anoxia</u>
DUE TO
(B) <u>Infective brain stem</u>
DUE TO
(C) <u>Prematurity (1lb. 13g.)</u> | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION
<u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<u>NO</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that he (this hospital) attended the deceased from <u>2-31 p.m. 4-14 1967</u> to <u>11:45 p.m. 4-14 1967</u> , that it (we) lost saw the deceased alive on <u>4-14 1967</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. He (We) (we) (did) not view the body after death. | | | | | | | |
| 23A. SIGNATURE
<u>H. Brenner</u> | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
<u>4-14-67</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>H. BRENNER</u> | | | | 23D. ADDRESS
<u>University Hospital</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE
<u>5-2-67</u> | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>MAY 9 1967</u> | | 25B. NAME OF REGISTRAR
<u>Robert E. Falkner</u> | | 25C. FUNERAL DIRECTOR
<u>HOSPITAL DISPOSAL</u> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 67-07045 4498 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 4498 | |
|---|-------------------------|---|---|--|---|---|---|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) <i>Baby Boy Dorsley</i> | | | | 2. DATE AND HOUR OF DEATH
<i>7 April 1967</i> <i>1 2.25 P. M.</i> | | | |
| 3. PLACE OF DEATH <i>BALTIMORE, MARYLAND</i> | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE _____ B. COUNTY _____ | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<i>38 UNIVERSITY HOSPITAL BALTIMORE</i> | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<i>Baltimore Md. 13-02</i> | | | |
| | | | | D. STREET ADDRESS (If rural, give location)
<i>816 Newington Ave.</i> | | | |
| 5. SEX
<i>M</i> | 6. RACE
<i>Negro</i> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<i>Never married</i> | 8. DATE OF BIRTH
<i>6 April 1967</i> | 9. AGE (In years last birthday)
<i>NB</i> | If Under 1 Yr. Months: Days | | If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<i>BALTIMORE, MD</i> | | 12. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> |
| 13. FATHER'S NAME
<i>unk.</i> | | | | 14. MOTHER'S MAIDEN NAME
<i>Margaret Dorsley</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>No</i> | | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS | | | |
| 18. <i>768.51</i>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)
<i>Sepsis.</i> | | | | CAUSE OF DEATH
(A) DUE TO
<i>Anticoagulants.</i> | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) DUE TO
<i>Pneumonia.</i> | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | (C) DUE TO | | | |
| 19A. DATE OF OPERATION
<i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<i>No</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (1) (this hospital) attended the deceased from <i>5:42 p.m. 6th April 1967</i> to <i>2:25 p.m. 7th April 1967</i> , that (1) (we) last saw the deceased alive on <i>7th April 1967</i> and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
<i>H. Brenner</i> | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
<i>7th April 1967</i> | |
| 23C. PHYSICIAN'S NAME (Type)
<i>H. BRENNER</i> | | | | 23D. ADDRESS
<i>UNIVERSITY HOSPITAL BALTIMORE, MD. 21201</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE
<i>5-2-67</i> | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State)
<i>UNIVERSITY MEDICAL SCHOOL</i> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<i>MAY 9 1967</i> | | 25B. NAME OF REGISTRAR
<i>R. E. F. F. F.</i> | | 25C. FUNERAL DIRECTOR
<i>HOSPITAL DISPOSAL</i> | | ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|------------------|--|-----------------------------|---|---|
| BIRTH NO. 67 4489 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 4489 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) BARRAS DELORES PEARL | | 2. DATE AND HOUR OF DEATH
MAY 4 1967 | | 1:00 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE MARYLAND B. COUNTY Baltimore Co. | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
ST. AGNES HOSPITAL
CATON & WILKENS AVENUES
BALTIMORE, MD. 21229 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE 53-00 | | | |
| D. STREET ADDRESS (If rural, give location)
140 NUNNERY LANE | | | | | |
| 5. SEX
FEMALE | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
MARRIED | 8. DATE OF BIRTH
2-14-07 | 9. AGE (In years last birthday)
60 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
SECTY. | | 10B. KIND OF BUSINESS OR INDUSTRY
OFFICE | | 11. BIRTHPLACE (State or foreign country)
IOWA | |
| 12. CITIZEN OF WHAT COUNTRY? | | | | | |
| 13. FATHER'S NAME
WILLIAM LA MAY | | 14. MOTHER'S MAIDEN NAME
FLORENCE (HARDY) LA MAY | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
507-16-3438 | | 17. INFORMANT
BALTO., MD. 21229
ST. AGNES HOSPITAL-CATON & WILKENS AVES. | |
| 18. 332 X
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) DUE TO
Central Infarction
(B) DUE TO
Atherosclerotic Vascular Disease
(C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH
Days
2 yrs.
11 yrs. | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Hypothyroidism and Hyperthyroidism | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (X) (this hospital) attended the deceased from APRIL 27, 19 67 to MAY 4, 19 67, that (X) (we) last saw the deceased alive on MAY 4, 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
J. Nelson McKay | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
May 4, 1967 | |
| 23C. PHYSICIAN'S NAME (Type)
J NELSON MC KAY | | 23D. ADDRESS
M.D. 6014 EDMONDSON AVE., BALTO., MD. 21228 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
5-6-67 | | 24C. NAME OF CEMETERY or CREMATORY
Landon Park Cem. | |
| 24D. LOCATION (City, town, or county) (State)
Baltimore, Md. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAY 9 1967 | | 25B. NAME OF REGISTRAR
Robert E. Taylor | | 25C. FUNERAL DIRECTOR
J. J. Connaughton
ADDRESS
J. J. Connaughton, Ind. | |

DATE: MAY 4 1957 TIME: 1:00 PM

ST. JAMES HOSPITAL
100 HUNTERY LANE
BALTIMORE, MD. 21201
C-11803
100

ST. JAMES HOSPITAL
100 HUNTERY LANE
BALTIMORE, MD. 21201

NAME: WHITE

WILLIAM L. A. V.

ST. JAMES HOSPITAL
100 HUNTERY LANE
BALTIMORE, MD. 21201

ST. JAMES HOSPITAL 100 HUNTERY LANE BALTIMORE, MD. 21201

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|--|--|--|--|--|
| BIRTH NO. 67 4500 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 4500 | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED
(Type or Print) <i>Alvah J. King</i> | | | 2. DATE AND HOUR OF DEATH
<i>5/7/67</i> <i>6³⁵</i> P.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<i>90 Bolton Hill Nursing Home</i> | | | A. STATE <i>Maryland</i>
B. COUNTY | | |
| 5. SEX <i>M</i> | | | 6. RACE <i>W</i> | | |
| 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) <i>W.</i> | | | 8. DATE OF BIRTH
<i>2/11/1896</i> | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>metal worker in metal factory</i> | | | 11. BIRTHPLACE (State or foreign country)
<i>Md.</i> | | |
| 10B. KIND OF BUSINESS OR INDUSTRY | | | 12. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | |
| 13. FATHER'S NAME
<i>WESLEY JACOB KING</i> | | | 14. MOTHER'S MAIDEN NAME
<i>ANNIE E. MILLER</i> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO.
<i>213-05-1702A</i> | | |
| 17. INFORMANT
<i>Lemora King</i> | | | ADDRESS
<i>834 Mansold St.</i> | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
<i>422.1</i> | | | CAUSE OF DEATH
(A) <i>bilateral C.V.A.'s.</i>
DUE TO
<i>middle cerebral artery thrombosis bilat. 8 weeks</i>
(B) <i>A.S.C.V.D.</i>
DUE TO
<i>several yrs.</i>
(C) | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | <i>decubitus ulcer left hip & shoulder several weeks.</i> | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<i>no</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>4-7-67</i> 19 to <i>5-7-67</i> 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>5-6-67</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<i>E. Elsworth Cook</i> M.D. | | | | 23B. DATE SIGNED
<i>5-7-67</i> | |
| 23C. PHYSICIAN'S NAME (Type)
<i>E. ELSWORTH COOK</i> | | | | 23D. ADDRESS
<i>2431 MARYLAND AVE.</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 24B. DATE
<i>5/10/67</i> | | 24C. NAME OF CEMETERY OR CREMATORY
<i>Krider Cemetery</i> | |
| 24D. LOCATION (City, town, or county) (State)
<i>Rural, Westminster Md.</i> | | 25A. DATE REC'D BY HEALTH DEPT.
<i>MAY 9 1967</i> | | 25B. NAME OF REGISTRAR
<i>Robert E. Farley</i> | |
| 25C. FUNERAL DIRECTOR
<i>J. S. Ziegler</i> | | ADDRESS
<i>Westminster Md.</i> | | | |

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U.S. DEPT. OF AGRICULTURE
WASHINGTON, D.C.

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JAN 10 1914
U.S. DEPT. OF AGRICULTURE
WASHINGTON, D.C.

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